A New Category for Diversity for those with Anomalous and Paranormal Experiences and Beliefs: The Care and Preservation of Private Experience and Belief in a Public and Scientific World [1]

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Introduction

The American Psychological Association (APA) is committed to psychologists being trained to comprehend, be open and sensitive to, and effectively work with, issues of individual and cultural diversity in a nondiscriminatory manner. Categories of diversity currently recognized by the APA include race, ethnicity, gender, sexual orientation, religion, age, disability, language, and socio-economic status. This chapter argues the case for adding a new category to the kinds of diversity already embraced by the APA in its educational and training literature for professional psychologists. It is suggested that this new category of diversity be created for individuals who have and present with personal anomalous experiences and beliefs that appear to fall outside of or contradict the dominant consensus reality and scientific paradigm, but where such individuals nonetheless otherwise appear psycho emotionally, cognitively, and behaviorally healthy and functional. The thesis being offered is that this kind of diversity, as represented by such individuals, should be equally protected under the same inclusive banner of diversity that supports, even ethically and legally mandates, as empathic and nonjudgmental a reception by licensed mental health professionals as is accorded to those populating the more familiar and already-accepted categories of diversity.

This chapter proposes to offer six domains that comprise this new diversity category for those presenting with anomalous and paranormal experiences, claims, and beliefs. These domains are:

1.) involving altered and higher states of consciousness;

2.) non-ordinary information processing capacity, such as exceptionally high creativity and transliminality, but not involving 'the psychic';

3.) experiences and beliefs involving psychic or parapsychological events, phenomena, processes, and abilities;

4.) unusual spiritual or transpersonal experiences, beliefs, and practices, particularly those defined as involving personal cases of 'spiritual emergence' and 'spiritual emergency';

5.) experiences and beliefs involving the non-physical, paraphysical, and trans-physical realm, and seeming to violate the laws of physics and the dominant materialist perspective, including possessing the character of 'non-locality';

6.) the otherworldly, including experiences with 'UFOs' and non-earthly, extraterrestrial, or other-dimensional beings. These categories will be returned to in more detail shortly.

Diversity and Cultural Competence

In its Guidelines *and Principles for Accreditation of Programs in Professional Psychology* (2007), the APA says that it is committed "To provide students with relevant knowledge and experiences about the role of cultural and individual diversity in psychological phenomena as they relate to the science and practice of professional psychology." Further, the *Report of the APA Task Force on the Implementation of the Multicultural Guidelines* (2008) refers to the rationale and need "for addressing multiculturalism and diversity in education, training, research, practice, and organizational change" (p. 3). The purpose of this chapter is to argue for the need for training and sensitizing mental health professionals to practice cultural competency to avoid adversely bringing their potential unconscious and conscious stereotyping and prejudice to bear when working with clients presenting with anomalous and paranormal experiences and beliefs by agreeing that they should be protected under this new category of diversity.

What happens when those in the helping professions, and in the counseling or clinical areas in particular, find themselves being asked to work with someone whose culture or subculture, belief system, worldview, or personal experience is considerably different from their own and from the dominant consensus reality? If some kind of common ground needs to be found within which to be able to connect and successfully work together, how does the professional come to terms with the *differentness* of his or her client? What if the nature of the client's experiences or beliefs deviates enough from what is considered normal, or even scientifically possible, that questions of mental abnormality or psychopathology may arise? Can we expect professionals to be, or become, sufficiently open-minded, tolerant, and understanding of a client with non-normative characteristics when those professionals have been trained and licensed to treat psychological states and behaviors that suggest the presence of one or more kinds of mental illness?

In keeping with the concept of cultural competency, Knapp and VandeCreek (2007) argue that psychologists need to respect the cultural values of their patients. However, patients from diverse cultural backgrounds may present goals and values that appear to conflict with Western values. When this occurs, psychologists should try to engage in respectful dialogue in which they clarify the values, appreciate that some cultures may express a value in a manner different from how it is expressed in Western cultures, and seek a therapeutic solution that satisfies both their own private values and the values of their patients. (Knapp & VandeCreek, 2007, p. 665)

This is all well and good when one is speaking of having understanding and tolerance with regard to members of a known culture that may express "goals and values that appear to conflict with Western values." However, a culture is defined as being comprised of a group or society having a number of things in common among its members; that is, culture is defined as "The beliefs, customs, arts, etc., of a particular society, group, place, or time; a particular society that has its own beliefs, ways of life, art, etc." (http://www.merriam-webster.com/dictionary/culture). But what about a single individual-- the client of a mental health professional, for example-- who is not part of an already established and recognized group with things in common? Can it make sense to consider the single individual as comprising a *culture-of-one*? If such were to be the case, the professional working with such an individual would need to develop an openness to and understanding of that individual to be able to best help. Operating like a phenomenological anthropologist, the professional would need to gradually learn the lived experience and worldview of that individual enough to create and share a common ground to be able to then best understand and treat.

Arguably, acting as an agent of the dominant consensus reality, the professional usually seeks to bring the client back from his or her own problem-making differentness and separateness enough to join, or re-join, functionally and adaptively, with the consensus reality and its underlining authoritative scientific and academic community. Ideally, this process should not be done at the cost of requiring those individuals to completely relinquish the very experiences, beliefs, and values that made them as different as they were in the first place; but very often this is just what is asked of them. To be acculturated into the dominant culture in an adaptive and mutually beneficial manner often requires that one no longer falls under the influence of, or being in allegiance to, that individual’s earlier culture-of-one. If a personal experience, belief, or worldview is seen by the professional as being associated with, even being the cause of, the individual’s mental, emotional, or behavioral problems, then the treatment of choice can all too often be a diminishing, or even excising, of what are seen as the estranging and crazy-making parts of that individual's thinking and experience. The other, arguably preferred, tack, and the one being taken by this chapter, is to help the individual, if he or

he so wishes, to retain whatever the questionable, highly individualistic experiences and beliefs were, and even retain one's earlier appraisals regarding them, but to learn at the same time ways to successfully adapt to the surrounding consensus reality and to live successfully as part of it.

As a professional possessing *cultural competence*, when a psychologist, psychiatrist, or counselor meets with an individual presenting with non-normative anomalous or paranormal experiences or beliefs, the question becomes: How should he or she interact and work with that individual? Having been trained as a licensed mental health professional, that training tends to instill caution in the professional to do no harm by not contributing to any potential mental instability or dysfunction or to exacerbating any problematic condition that may already be there. So, there may be a professionally conditioned tendency on the part of the clinician not to encourage or appear to agree with and support a client's experiences or beliefs that deviate too much from the norms of the consensus reality and the views of what is real and acceptable in the eyes of mainstream science and academia. Nonetheless, as Watson et al. reminds us, "The assertion has appeared repeatedly in the literature that it is unethical for counselors to provide clinical services to clients who are culturally different from themselves if the counselor is not competent to work effectively with these clients" (Watson et al., 2006, p.1). So, it can be argued that this competence must be with regard to an understanding of the client's world as well as having competence with regard to the dominant consensus reality and scientific community.

With regard to multicultural competence and practice, a number of different orientations have been described. According to the perspective of *absolutism* or *ethical universalism,* psychologists should adhere to the correctness and universality of the dominant Western ethical and cultural standards and experience and work with their clients using this lens, helping them to conform to such norms at the cost of their own culturally different ways (Knapp & VandeCreek, 2007; Harper, 2006). In contrast, according to the perspective of *moral relativism*, psychologists should avoid allowing dominant Western values and views to encroach on what is going on in the therapy room if such conflicts with the patient's own indigenous culture, beliefs, and experiences, or what in this chapter we are calling his *culture-of-one* (Knapp & VandeCreek, 2007; Harper, 2006). However, for most clinicians it can be difficult to support this much autonomy for the client if it is too divergent from the norm and from the clinician's own beliefs and experiences. A third perspective, *soft universalism* or *moral realism,* allows for tolerance for cultural differences and attempts to work with the individuality and autonomy of the client. According to this view, views and values between clinician and client can differ, as well as between the dominant culture and the client's culture, but some behaviors, beliefs, and experiences on the part of the client would still be deemed too divergent to be tolerated or condoned (Knapp & VandeCreek, 2007; Rosenstand, 1994; Tjeltveit,1999).

Most licensed mental health practitioners today have learned to adopt, and/or have been professionally trained to acquire, a certain degree of *multicultural relativism* that informs how they see and work with others. Nonetheless, across how they were educated and trained and how they operate as practitioners, there tends to be a consensus and a shared understanding about what constitutes the nature of what is considered *real.* This sense of what is real underlies our consensus reality-- or the reality that in normal waking consciousness we agree to as being the common reality we are experiencing, arguably even should be experiencing. We experience it as external to us and as having an objective and independent nature separate from our subjective consciousnesses experiencing it. Furthermore, our understanding of this agreed-to consensus reality we are experiencing together is in accord with and best explained for most of us by the dominant scientific paradigm, which happens to be fundamentally materialistic in nature.

In most societies, there are groups of people who are denied access to the rights and privileges enjoyed by others on account of their physical, biological, social, or other traits. These segments of the population are often called "minorities". There is, however, disagreement over the exact meaning of the term "minority" (Blumenfield & Raymond, 2013). Members of many minorities report experiencing prejudice toward them at the hands of others. "To feel prejudice toward an individual or group is to hold an adverse opinion or belief without just ground or before acquiring sufficient knowledge" (Adams et al., 2013, p. 22). One of the purposes of this chapter is to ask us to consider a new minority comprised of those having anomalous and paranormal beliefs and experiences in order to help us acquire "sufficient knowledge" with regard to them in an attempt to lessen or counteract the prejudice felt by many of them at the hands of others who do not share their non-ordinary experiences or beliefs.

The Anomalous and Paranormal

The Anomalous

The editors of the pioneering APA-published book, *Varieties of Anomalous Experience: Examining the Scientific Evidence*, define an *anomalous experience* as

> an uncommon experience (e.g. synesthesia) or one that, although it may be experienced by a substantial amount of the population (e.g., experiences interpreted as telepathic), is believed to deviate from ordinary experience or from the usually accepted explanations of reality... We also contrast *anomalous,* a term that does not have any necessary implication of psychopathology, with *abnormal*, a term which usually denotes pathology. Notwithstanding the presence of anomalous experiences in case studies of disturbed individuals, surveys of nonclinical samples have found little relationship between these experiences and psychopathology. (Cardena et al., 2000, p. 4)

The authors also point out that "to determine that an experience is uncommon or anomalous, we have to consider the cultural framework in which the evaluation of the experience occurs" (Cardena et al., 2000, p. 5). One culture's, or one individual's, anomalous or paranormal belief or experience may be for others normal and acceptable, even highly prized. Noted psychologist Michael Eysenck addresses some of the factors underlying anomalous experience, including cognitive, personality, and biological factors; that some individuals ("sheep") tend to believe in the anomalous, while others ("goats") are strong skeptics or disbelievers; that a correlation can be found between anomalous experience and fantasy-proneness, extroversion and openness to experience, temporal lobe lability, and electro hypersensitivity; also that there can be psychodynamic factors, childhood loneliness or insecure attachment, deception and self-deception, superstition, coincidence, and perceptual and memory error associated with anomalous experience (Eysenck & Flanagan, 2001).

There is a psychological assessment instrument used to evaluate an individual's anomalous experience, called the Anomalous Experiences Inventory (AEI). A sampling of the items include checking whether or not one is “able to communicate with supernatural forces;" if one has "experienced other planes of existence beyond the physical," or whether one has ever "met an extraterrestrial" (Gallaghar & Kumar, 1994).

A British study investigating whether anomalous experiences lead to clinically relevant psychotic symptoms found that it depends on how they are appraised, the context in which they occurred, and the individual's emotional response. Three groups were used: one group of subjects already diagnosed with the DSM-IV psychotic disorder; one at-risk group seeking help with regard to their anomalous experiences; and a group of individuals who had never received a diagnosis or treatment for a psychotic disorder but had at least occasional experiences of an anomalous kind. Members of the third group reported more benign and positive appraisals of their anomalous experience and yet were no less aroused by them than members of the other two groups (Brett et al., 2007). The point being made was that simply having anomalous experiences or beliefs need not necessarily be correlated with any kind of distress or psycho emotional or behavioral maladaptive or dysfunction. A case might even be made that a clinician appraising in a negative or psychopathological manner an individual's anomalous experience might contribute to that individual moving from a positive and benign relationship to the experience to one of self- doubting and acceptance of a mental health professional's negative appraisal.

In philosopher and historian of science Thomas Kuhn's influential book, *The Structure of Scientific Revolutions* (Kuhn, 1962), he makes a case for how anomalies-- phenomena that are unable to be explained by the dominant scientific paradigm of the time-- play a key role in how our scientific understanding gradually evolves to eventually accommodate those anomalies. What Kuhn calls *normal science* "is predicated on the assumption that the scientific community knows what the world is like," and it is dedicated to defending this assumption. However, in doing so, "normal science often suppresses fundamental novelties because they are necessarily subversive of its basic commitments" (Kuhn, 1962, p. 5). For Kuhn, a *scientific revolution* takes place when an anomaly confronting the scientific community cannot be explained according to the current paradigm of its normal science and thus can potentially subvert the existing tradition of scientific perspective and practice. A shift comes when a scientific revolution is provoked by finally learning from the anomalous by coming to terms with it on its own terms, not according to the terms of normal science. Thereby, "a scientist's world is qualitatively transformed [and] quantitatively enriched by fundamental novelties of either fact or theory" (p. 7). Normal research for Kuhn means "research firmly based upon one or more past achievements that some particular scientific community acknowledges for a time as supplying the foundation for its further practice" (p. 10); but our science cannot evolve in this manner. Research based on the dominant scientific paradigm of the time is "an attempt to force nature into the preferred and relatively inflexible box that the paradigm supplies" (p. 24). Science thus becomes a closed system incapable of growth and of understanding the new because "normal scientific research is directed to the articulation of those phenomena and theories that the paradigm already supplies" (p. 24) When the novelty of the anomalous ceases to be ignored, denied, or explained away in terms solely of the current normal science perspective, dealing with and learning from these anomalies can allow scientists to be able to "see nature in a different way" (p. 53) than had been able to be the case using the lenses of the previous normal science. For Kuhn, invention and discovery arise from the failure of normal science to accommodate and understand the anomalous, and it is such invention and paradigm of the time is "an attempt to force nature into the preferred and relatively inflexible box that the paradigm supplies" (p. 24). Science thus becomes a closed system incapable of growth and of understanding the new because "normal scientific research is directed to the articulation of those phenomena and theories that the paradigm already supplies" (p. 24) When the novelty of the anomalous ceases to be ignored, denied, or explained away in terms solely of the current normal science perspective, dealing with and learning from these anomalies can allow scientists to be able to "see nature in a different way" (p. 53) than had been able to be the case using the lenses of the previous normal science. For Kuhn, invention and discovery arise from the failure of normal science to accommodate and understand the anomalous, and it is such invention and

discovery that can increase our understanding as the earlier paradigm, no longer adequate for dealing with the anomalous and new, is replaced with a new paradigm with greater explanatory power and utility. A kind of benevolent crisis leading to growth and self-transcendence occurs when the normal science of any one time is unable to solve the puzzles presented by the anomalies only by using the thinking and methods to which normal science limits itself. According to Kuhn, our scientific understanding of the world and of ourselves continuously grows thanks to what the anomalous has to teach us when we finally stop ignoring it, dismissing it out of hand, ridiculing it, or force-fitting it to assimilating to normal science, which the anomalous, by its very nature, transcends. Therefore, in Kuhn's view, the anomalous has a crucial role to play in the advancement of our scientific understanding.

The Paranormal

Webster's Dictionary defines paranormal as "very strange and not able to be explained by what scientists know about nature and the world." Synonyms include, "metaphysical," "otherworldly," "supernatural," "transcendent," and "unearthly" (**www.merriam-webster.com**). The American Parapsychological Association-- the primary professional organization representing the discipline of parapsychology-- defines paranormal phenomena as "apparent anomalies of behavior and experience that exist apart from currently known explanatory mechanisms that account for organism-environment and organism-organism information and influence flow*"(*Irwin, 1999, p. 1). In a conceptual treatment published in the neuroscience journal Cortex, "A cognitive basis of paranormal beliefs" is presented "which involves an extended overlap between the representations of living and nonliving things, both physical and mental states and…[between] self and non-self" (Brugger & Mohr, 2008, p. 1293).

Cultural and new religion scholar Joseph Laycock points out that "One area that has been ignored for far too long is the enormously widespread belief in such things as ghosts, UFOs, psychic abilities, and divination-- phenomena that frequently fall under the category of 'paranormal' …[but] at long last, it seems that scholarship has begun taking the paranormal seriously" including a movement "to locate the paranormal somewhere near the intersection of deviant religion and deviant science" (Laycock, 2000, pp. 92-93). Similarly, fellow social scholar Kripal writes, "I am defining the paranormal as the sacred in transit from the religious and scientific registers into a parascientific or 'science mysticism' register" (Kripal, 2010, p. 9). As Eastern Michigan University sociologist Marcello Truzzi describes it, the term paranormal was created to designate phenomena considered natural-- not supernatural-- and which eventually should find scientific explanation but thus far escaped such explanations... Unfortunately, many critics of the paranormal continue to equate anything purportedly paranormal with the supernatural. This is particularly ironic since those who truly believe in the supernatural (such as the Roman Catholic Church when it speaks of miracles) have long understood the paranormal explanation precludes a supernatural one. (Radin, 1997, p. 18)

Regarding the related term *supernatural*, according to former astronaut, physicist, and Institute of Noetic Science founder Edgar Mitchell, "There are no unnatural or supernatural phenomena, only very large gaps in our knowledge of what is natural, particularly regarding relatively rare occurrences" (Mitchell, 1979, p. 3).

Six Domains Comprising the New Diversity Category

As earlier mentioned, this chapter seeks to expand the notion of diversity in psychological theory and practice to include a new non-pathological category of those having anomalous and paranormal experiences and beliefs. It is suggested that this new category include the following six domains:

1) The first is comprised of those capable of altered and higher states of consciousness, as well as the kinds of experiences, abilities, and beliefs regarding them.

According to psychiatrist Arnold Ludwig, altered states of consciousness (ASCs) are defined as any mental state(s), induced by various physiological, psychological, or pharmacological maneuvers or agents, which can be recognized subjectively by the individual himself (or by an objective observer of the individual) as representing a sufficient deviation and subjective experience or psychological functioning from certain general norms for that individual during alert, waking consciousness. (Ludwig, 1969, p. 11)

Besides normal everyday waking consciousness, the field of psychology offers a taxonomy of different kinds of ASCs, including the dreaming state, the hypnagogic state (moving from waking toward sleep), the hypnopompic state (moving from sleeping toward waking), the hyperalert state, the lethargic state, states of rapture, states of hysteria, states of fragmentation or dissociation, regressive states, meditative states, trance states, reverie, the daydreaming state , internal scanning (especially introspection with regard to one's own body and its states), stupor, coma, stored memory, and *expanded* conscious states (Krippner, 1972).

A century earlier, William James, the American pioneer of modern philosophy and psychology, and the author of the first textbook on psychology, the first with its own chapter on consciousness, characterized altered states of consciousness when he wrote: "*Our normal waking consciousness, rational consciousness as we call it, is but one aspect of consciousness, whilst all about it, parted from it about the filmiest of screens, their live potential forms of consciousness entirely different." He said that "We may go*

through life without suspecting their existence, but …. Apply the requisite stimulus. And they are there in all of their completeness, definite types of mentality...No account of the universe in its totality can be final which leaves these other forms of consciousness quite disregarded" (James, 1902, p. unknown).

A case can be made that a variety of the anomalous and paranormal experiences and beliefs being presented in this chapter involve just such "different types of mentality," such "other forms of consciousness" with which the majority of us are relatively unfamiliar. However, for those of us who have had first-hand experience with some of these other forms of consciousness and what they can allow us to experience by means of them, the thought that the field of psychology, and of clinical psychology in particular, might consider a category of diversity to sensitize and inform clinicians and counselors about their nonpathological and even valuable *otherness* may prove comforting.

Psychiatrist John Nelson, in his book, *Healing the split: Integrating spirit into our understanding of the mentally ill*, writes about both the unwanted and wanted traits of different kinds of altered states of consciousness:

> *a psychotic ASC can so shatter a person's fundamental sense of selfhood that leaves him or her devoid of the inner unity and consistency necessary for life to be satisfying or meaningful. Those who eventually return to the ordinary state of consciousness often do so with a crippled trust in their sense of self that lasts a lifetime. Yet the most sublime forms of art, philosophy, religion, and science also have been profoundly influenced by people whose perception range from the uncommon to the mysterious. Hence madness has been alternately glorified and reviled*. (Nelson, 1994, p. 30)

Psychiatrist Roger Walsh and his wife, transpersonal psychologist Frances Vaughan, also saw the state-specific nature of altered state of consciousness and of much of our information processing. They also suggested that perhaps there should be a kind of nonjudgmental pluralism with regard to viewing and working with those diagnosed with psychosis within this context:

> *The transpersonal perspective holds that a large spectrum of altered states of consciousness exist, that somewhere potentially useful and functionally specific... And that some of these are true "higher" states. A wide range of literature from a variety of cultures and growth disciplines attests to the attainability of these higher states. Since each state of consciousness reveals his own picture of reality, it follows that reality as we know it (and that is the only way we know it) is also only a relatively real. Put another way, psychosis is attachment to any one reality.* (Walsh & Vaughan, 1980, pp. 54, 55)

If psychosis is a kind of state-specific stuckness in one of many possible states of consciousness, then perhaps a useful way of working with psychotics presenting with anomalous and paranormal experiences and beliefs is to help them become unstuck enough with regard to their usual ASC to be able to move between, or bridge and mutually embrace, both the original state of consciousness being deemed psychotic and the broader massively shared normative consensus reality.

Perhaps more than any other psychologist, Charles Tart has studied the mechanisms that may lie behind the "attainability" of such altered or higher states of consciousness. For Tart, "state-dependent" or "state-specific" experiences are those that are accessible only as a function of being in a specific, discrete state of consciousness that is markedly different from normal waking consciousness (Tart, 1975, pp. 201-205). It appears that some of us happen to be organized and predisposed to be able to "tune" state-specifically to what could be seen as anomalous stations or channels of information and their experiential content, while the majority of us do not have this capability. Built on this concept, "state-specific science," according to Tart, may be conducted where two or more scientists or researchers can transiently share a similar-enough altered state of consciousness that they can conduct experiments and share their information with each other while temporarily comprising their own small-n consensus reality different from the much-larger surrounding one (Tart, 1975, pp. 206-228). In this sense, it is possible that in the clinical and counseling area, the professional might be able to temporarily alter his or her consciousness in order to more closely align with the state of consciousness of the client to allow a kind of transient two-person contact and communication on a more shared wave-length.

2) Non-ordinary information processing capacity, not apparently psychic:

Very High Creativity. In this regard, those whose creativity has an exceptionally high, even problematic, level of information processing capacity may need help in managing productively their creativity both for themselves and for others, rather than simply being psychopathologized for their differentness. Consider the following psychologically sophisticated depiction of the relationship between creativity and psychopathology, when the level of creativity can reach a non-normative level:

> *Creativity is considered a positive personal trait. However, highly creative people have demonstrated elevated risk for certain forms of psychopathology…. A model of shared vulnerability explains the relation between creativity and psychopathology... Elements of shared vulnerability include cognitive disinhibition (which allows more stimuli into conscious awareness), an attentional style driven by novelty salience, and neural hyperconnectivity that may increase associations*

among disparate stimuli. These vulnerabilities interact with superior meta-cognitive protective factors, such as high IQ, increased working memory capacity, and enhanced cognitive flexibility, to enlarge the range and depth of stimuli available in conscious awareness to be manipulated and combined to form novel and original ideas. (Carson, 2011, p. 114)

Positive Schizotype: While certain aspects of schizotypal personality disorder and positive schizotype will be considered further in a later section of this chapter, it good to point out here, under this domain of non-ordinary information processing capacity, that far from being a pathological condition, vulnerability to schizophrenia spectrum disorder potential psychopathological conditions (i.e. schizotype) may be related to highly valued abilities, such as creativity, giftedness, and high intelligence (Dagnall, 2010; Kelley, 2010; Kelley, 2011).

Transliminality: Is a "hypersensitivity to psychological material emanating from the unconscious, and, simultaneously, a hypersensitivity to stimulation from the external environment" (Thalbourne, 2006). What is sometimes called having a "leaky mental threshold"… [can] include "positive schizotype, paranormal beliefs, creativity, fantasy proneness, absorption, and sleep-related anomalous experiences" (Kelley, 2010, p. 359).

Australian parapsychologist Michael Thalbourne writes that, "*It is argued that mystical and paranormal experiences are not necessarily pathological, although they may be associated with these disorders and indeed are more prevalent in these disorders. A single underlying factor called transliminality ('psychological material crossing thresholds into consciousness') illuminates the observed correlations between mystic, paranormal, manic, and schizotypal experiences*" (Thalbourne, 2006, p.143).

Related to what could be construed as having extremely "leaky thresholds," noted author Aldous Huxley, in his influential study, *The Doors of Perception*, wrote, Each of us is potentially Mind at Large. But insofar as we are animals, our business is at all costs to survive. To make biological survival possible, Mind at Large has to be funneled through the reducing valve of the brain and nervous system. What comes out the other end is a measly trickle of the kind of consciousness which help us to stay alive on the surface of this particular planet.... Certain persons, however, seem to be born with a kind of bypass that circumvents the reducing valve. (Huxley, 2008, p. 6)

Some of us have psychobiological valves that do not reduce enough such Mind at Large and we can therefore become susceptible to being engulfed by the unbridled contents of our own consciousness, or of a larger consciousness than our own, and thus need help in adjusting our reducing valve.

Nonetheless, although some non-ordinary states of consciousness can be related to maladaptive cognitions and behaviors, William James saw the value to society of such *differentness* when he wrote that "*this Borderland insanity… loss of mental balance...has certain peculiarities and liabilities which, when combined with the superior quality of intellect in an individual, make it more probable that he will make his mark and affect his age, than if his temperament were less neurotic*" (James, 1902, p. 24).

In another example of a potentially problematic altered state of consciousness, the manic state of someone with bipolar disorder or delusions of grandeur can manifest as a case of a potentially dysfunctional failure of the reducing valve to keep at bay an excessive influx of this Mind at Large. Nonetheless, periods of temporarily bypassing or lessening the effect of the reducing valve can be seen as leading to rare flights of extraordinary genius or episodes of transcendent consciousness that can provide invaluable contributions to the culture at large most of whose members are relegated to only receiving what Huxley earlier called "a measly trickle of the kind of consciousness which helps us stay alive on the surface of this particular planet" (Huxley, 2008, p. 6).

3. The domain of s**piritual or transpersonal experiences, beliefs, and practices** operating outside the more familiar widely followed religions, particularly those that the individual develops for him/her self and that fall under the concept that psychiatrist Stanislav Grof and his wife Christina (1989) called "spiritual emergence" or "spiritual emergency." A personal spiritual emergence can turn into a spiritual emergency when the process sometimes becomes particularly distressing and estranging for the individual, and/or is misconstrued by others as some kind of psychotic break from functioning in the shared reality.

J.M. Holden writes that these kinds of spiritual emergence experiences typically fall into one of the following 10 categories: (a) shamanic crisis, in which one loses contact with one's environment and undergoes a psychospiritual death and rebirth experience; (b) the awakening of kundalini...(c) episodes of unitive consciousness, a sense of oneness with others, nature, or the entire universe; (d) psychological renewals to return to the center...(e) crisis of psychic opening, in which paranormal phenomena occur spontaneously and may include out of body experiences or telepathic or clairvoyant abilities; (f) past life experiences...; (g) communication with spirit guides and channeling...: (h) near-death experiences...; (i) experiences of close encounters with UFOs, in which the visitors are understood to be advanced intellectually and spiritually; and (j) possession states involving control of the individual by a darker power. (Holden in Grof & Grof, 1989, pp. 13-14).

The purpose of this chapter is to argue for bringing empathy and as much understanding and unconditional positive regard as possible to support and help those comprising our suggested new diversity category. And here, with regard to the particular domain of those presenting with non-normative spiritual emergence and spiritual emergency experiences, Holden contends that

> *As we prepare for the changes and challenges of the 21st century, it is now more critical than ever for mental health professionals to possess an awareness of and sensitivity to the diverse spectrum of religious and spiritual issues that may arise in clinical settings... Many individuals manifesting characteristics of altered states have sought help and support from traditional counseling. Frequently such people have been pathologized, resulting in diagnoses of schizophrenia, schizophrenoform disorder, brief psychotic disorder, or adjustment disorder. Yet evidence is accumulating in the professional literature celebrating ASCs not as a breakdown but a breakthrough.* (Holden, 1999, p. 163)

Transpersonal psychologist and author Ken Wilber agrees, arguing that "*The easiest way to be labeled schizophrenic in our society is to let it be known that you feel that in the deepest part of your being you (and all sentient beings) are one with the infinite Spirit, one with the universe, one with All-- an insight that every wisdom culture the world over has held to be not the depths of mental illness but the pinnacle of human understanding. This intuition of the Supreme Identity, shared by all beings, is for such cultures not the ultimate pathology but the ultimate liberation... The only major culture to ignore and devalue the perennial philosophy has been, alas, our own modern culture of secular materialism and brutish scientism."* (Wilber quoted in Nelson, 1994, pp. viii, ix)

Psychiatrist John Nelson adds that "*the time seems right for a radical new theory of madness that takes into account all of our being... The transpersonal perspective views 'normal' consciousness as a necessary and useful, but defensively contracted, state of reduced awareness that enables the individual to live in a social world but blinds him or her to greater spiritual potentials that lie beyond the ego or world-self*" (Nelson, 1994, p. xxi).

Returning to spiritual experiences when they can become a problem for the individual, Dutch psychologist Kohls comments that "*The concept of spiritual emergency assumes that spiritual distress, although it may bother an individual at least for a certain period of time, may actually lead to greater fulfillment and personal improvement in the long run, if dealt with properly*" (Kohls, 2012, p. 139).

4.) **Psychic or parapsychological.** Roman Catholic Priest, Sociology Professor, and Research Associate with the National Opinion Research Center (NORC), Andrew Greeley reported on a University of Chicago survey of 1500 adult Americans that found a majority, or 67%, reported having had some kind of psychic experience, and that there may be an even higher percentage in recent years (Greeley, 1987). It may be that once non-normative domains, such as the psychic, may be taking on a more normative and majority, and less of a minority or marginal, status.

Originally called "psychical research," explored for almost a hundred years by the British Society for Psychical Research and the American Society for Psychical Research (cofounded by William James), is most recently represented by the discipline of parapsychology (a member science of the prestigious American Association for the Advancement of Science since 1966). The Parapsychological Association is the primary international professional organization of scientists and scholars engaged in the study of PSI (or 'psychic') experiences and phenomena.

There are three main domains that are understood to be studied by parapsychology: extrasensory perception, psychokinesis, and survival studies (Thalbourne, 2003). The first domain, extrasensory perception (or ESP), also known as "anomalous cognition" or "receptive psi", includes telepathy, clairvoyance (seeing with the mind's eye) or remote viewing, clairaudience (hearing with the mind's ear), clairesentience (a kind of inner feel or sensing), precognition and retrocognition (seeing or knowing the future and the past), and psychometry (receiving information from the vibrations of objects that have been previously touched by others) (Thalbourne, 2003). Parapsychologist Russell Targ notes that "There is not a consensus in the scientific community as to whether such experiences [i.e., psi-related] represent anomalous information transfer or are entirely due to various forms of misinterpretation and self-delusion" (Targ et al., 2000, p. 235).

The second domain, psychokinesis (PK), or the study of anomalous effects of mind or intention on inanimate physical systems, or on living systems ("bio-PK") which includes psychic, mental, or faith healing, and distant mental influence on living systems ("DMILS"). PK can also include materialization, dematerialization, and transubstantiation, and levitation and teleportation (Thalbourne, 2003).

The third domain of parapsychology involves the study of whether or not there is survival of physical death, which includes the notion of consciousness able to operate separate or independent from the physical body and brain; this includes the concept of discarnate human spirits who have survived the death of their physical bodies, and related ghosts, hauntings, and apparitions, mediumship and channeling (communication between physically embodied and other kinds of beings and intelligence), near-death experiences

(NDEs) and out-of-body experiences (OBEs), reincarnation and evidence of past lives, spirit possession, and electronic voice phenomenon (EVP) and instrumental trans-communication (ITC), the last two involving attempted communication with surviving human spirits through the use of tape recorders, radio, television, and computers (Klimo, 1998, pp. 345-356; Thalbourne, 2003).

According to noted parapsychologist Dean Radin, *After a century of slowly accumulating scientific evidence, we now know that some aspects of psychic phenomena are real…. Psi supports the concept of a deeply interconnected 'conscious universe', not merely a psychological coping mechanism, but a reality. As science shifts toward a worldview that supports rather than denies our deepest psychological needs, we can expect significant beneficial consequences for society's mental health.* (Radin, 1997, pp. 290-293)

Radin also points out that "*today, informed skeptics no longer claim that the outcomes of psi experiments are due to mere chance because we know that some parapsychological effects are, to use skeptical psychologist Ray Hyman's words, "astronomically significant." This is a key concession because it shifts the focus of the debate away from the mere existence of interesting [i.e., psychic or paranormal] effects to their proper interpretation. The concession also puts to rest the decades-long skeptical questions over the scientific legitimacy of parapsychology. It states, quite clearly, that skeptics who continued to repeat the same old assertions the parapsychology is a pseudoscience, or that there are no repeatable experiments, are uninformed not only about the state of parapsychology but also about the current state of skepticism!* (Radin, 1997, p. 209)

A recent offshoot of parapsychology is what is being called by Klimo (1998a) and others the emerging subfield of "clinical parapsychology," to which we will return in more depth later in this chapter. It combines training in licensed counseling or clinical mental health care practice, on the one hand, and parapsychology and consciousness studies, on the other. Clearly, this emerging field can prove helpful to those professionals who may wish to specialize in working in a non-psychopathologizing manner with members of our new diversity category whose kinds of anomalous and paranormal experiences are particularly of the parapsychological kind.

Also, related to parapsychology, is the field of "anomalous psychology," which uses mainstream physics, biology, and, especially, psychology to explain all cases of anomalous or paranormal experiences or abilities in its own mainstream terms, thus reducing all candidates for the paranormal to the realm of the present-day normal.

5.) The paraphysical, transphysical, and other-dimensional. This domain involves experiences and beliefs that appear to violate or go beyond our current commonly held understanding of the nature of physical reality and that transcend the dominant scientific paradigm's limiting conditions regarding space and time, matter and energy, dimensional "four space" (i.e., the usual three dimensions of space and the fourth of time), and the nature of causality (violating usually understood causal relations that involve "nonlocality"). This category is related to the earlier category of "Psychic or Parapsychological" and the latter category of "Experiences and Beliefs Involving the Otherworldly, UFOs and Extraterrestrials."

If an individual reports experientially entering a realm that seems to not be physical in nature, that does not seem to be of the same physical reality one is used to experiencing in normal waking consciousness with one's body, physical senses, and that can be consensually validated and corroborated by others, then what, and where, is that individual experiencing? Most of the rest of us would consider that he is having an experience not of part of the one objectively real physical reality external to us that we are used to partaking of in normal waking consciousness. But, instead, he would be considered as having an experience of something that is "inner," mental, of the psyche (psychic) or subjective in nature, in contradistinction to something that is physical and objectively, not subjectively, real. Yet, some of us might wish to consider and explore this apparently non-or trans-physical experiential realm as if it were an extension of the currently understood physical world. Such an attempt to extend the physical world could involve notions of subtle

energies, higher frequencies, higher dimensionality, a parallel universe, and so on. Some, including the late Institute of Noetic Sciences researcher, Brendan O'Regan, have coined the term *paraphysics* to talk about such an attempt to extend our understanding of the nature of the physical. Conceptually, paraphysics could be seen to relate to (or be beside) physics in a similar way that the term parapsychology could be seen as being beside psychology. In both cases, the prefix "para-" implies being beside or possibly going beyond. Webster's Dictionary defines paraphysical as "resembling physical phenomena without recognizable physical cause" (http://www.merriam-webster.com/dictionary/paraphysical).

Carl Jung contributes to this perspective when he writes, "*It is almost absurd prejudice to suppose that existence can only be physical. As a matter of fact, the only form of existence of which we have immediate knowledge is psychic [i.e., in the mind]. We might as well say, on the contrary, that physical existence is a mere inference, since we know of matter only insofar as we perceive psychic images mediated by the senses*." (Carl Jung, quoted in Radin, 1997, p. 290)

Similarly, parapsychologist Dean Radin writes that "*we're finding that our understanding of the physical world is becoming more compatible with psi [i.e., psychic phenomena*]" (Radin, p. 287). Related to this, Jung had earlier coined the term *psychoid* to refer to a reality which simultaneously possesses both the qualities of the psychic/psychological and of the physical: "*Since psyche and matter are contained in one and the same world, and moreover are in continuous contact with one another and ultimately rest on irrepresentable, transcendental factors, it is not only possible but fairly probable even that psyche and matter are two different aspects of one and the same thing*" (Jung, 1969).

Harvard professor, psychiatrist, and Pulitzer Prize winning author, John Mack, from whom we will hear more in the next section, echoes this kind of paranormal, paraphysical, and larger reality thinking when he writes that "*the possibility that beings, spirits, or anything at all could "cross over" from the unseen or "other" world into our material reality. This crossover seems to be regarded as a regular occurrence in many if not most indigenous cultures, but in our Western or scientific/materialist society, the domains of spirit and matter have been kept separate and distinct, and the possibility of traffic between them is looked upon as doubtful if not altogether impossible."* (Mack, 1999, p.5)

6. Experiences and beliefs involving the Otherworldly, UFOs and Extraterrestrials. This final domain includes individuals claiming to be "experiencers," "contactees," or "abductees" with regard to UFO-associated extraterrestrial beings, with such experiences usually involving reports of "high strangeness." More detail is being provided here for this category of anomalous and paranormal experience and belief than has been done for the previous five because the subjects of flying saucers and extraterrestrials have received more than 60 years of relatively high visibility in the media and in the mind of the public at large compared to the other categories we are considering. UFOs and extraterrestrials have also been more associated with everything from perceived silliness, fraud, and hoaxing, to attempts to escape reality, and at least transient episodes of "craziness," of taking leave of one's own ego strength and the embedding consensus reality and of the truths espoused by the dominant scientific paradigm and its core materialistic and Earth-centric understandings.

So, what is the prevailing cultural and scientific attitude toward UFOs and extraterrestrials and people's reported experiences and beliefs about them? A 1987 Gallup poll assessed the American population's opinion of unidentified flying objects (UFOs). The survey contained four questions: 1.) "Have you heard or read about UFOs?" 2.) "Have you, yourself, ever seen anything you thought was a UFO?" 3.) "In your opinion, are UFOs something real, or just people's imagination?" and 4.) "Do you think there are people somewhat like ourselves living on other planets in the universe?" (Gallup, 1998, pp. 52-54).

Summarized by researcher John Saliba, the results showed that over 80% of the population has some awareness of UFOs and 9% claimed to have seen something that could have been one. About 50% of the sample thought that UFOs are real objects and not constructs of the imagination an intelligent beings existed somewhere else in the universe. Over 50% of those who believe in UFOs had attended college... Comparison between the Gallup surveys demonstrates that beliefs about flying saucers have not changed much since the late 1970s; it also shows that interest in UFOs runs high. (Saliba, 1995, p. 15)

Looking at more recent polls, in a large 1996 Newsweek magazine poll: 48% said they believe UFO's are real; 29% believe that we have made contact with aliens; and 48% believe that there is a government conspiracy to cover it up. In a 1997 Gallup Poll, 87% Americans have read or heard about UFO's; 12% reported that they had seen something that they thought was a UFO; 45% think UFO's have visited earth; 48% believe UFO's are something real; 31% believe UFO's are the result of people's imagination; 72% believe that there is life in some form on other planets in the Universe; 38% believe that there are people somewhat like ourselves living on other planets; and 71% believe that the US Government knows more about UFO's than it's telling.

In a large 1997 CNN/Time Magazine Poll: 80% said they believe that the government is hiding the existence of extraterrestrial life forms; 54% believe intelligent life exists beyond earth; 64% believe aliens have contacted humans; 50% believe that aliens have abducted humans; 93% have never been abducted; 91% have never had contact with aliens; 75% had never seen a UFO or knew of anyone who had; 37% believe that aliens have contacted the US government; and 75% believe that a UFO crashed near Roswell, NM. (The above is a summary of some recent opinion polls on UFOs, UFO evidence from www.ufoevidence.org/documents999.htm, retrieved Feb 9, 2014.)

In an ambitious and costly 1991 scientifically conducted Roper Poll and follow-up survey funded by the Bigelow Holding Company of Nevada, out of 5947 respondents, referring to types of experience previously correlated with extraterrestrial encounters, 18% reported awakening paralyzed with a strange being in the room; 14% felt they have left their body; 13% experienced missing time; 11% had seen a ghost; and 7% said they had seen a UFO. On the basis of this poll, its size, and the external validity of its design, the Roper organization believed that a generalization could then be made that up to 2% of Americans (5 million) may have had an abduction or contactee type experience. The results and interpretation of this Roper survey was later sent to 100,000 psychiatrists, psychologists, and counselors throughout the US in an attempt to make them more aware of the possibility of these encounter and abduction phenomena and how widespread they may well be (Mack et al., 1992).

So how do anomalous and paranormal experiences and beliefs of this particular otherworldly kind affect those involved? Professional psychologist Richard J. Boylan states the UFO experience is definitely meant to shake us out of our perceptions of the world. It brings our minds out of our mundane, material, and trivial society and changes our complacent attitudes of where and who we are. It dispels our blind beliefs in our myths and challenges our collective denial of the greater reality – the Universe. (Boylen, 1994, p. 133)

Based upon his extensive case study research with extraterrestrial encounters, psychiatrist and author John Mack asked us to consider that first, the experiences seem to be created, as if by design, to shatter (the word virtually all of abductees use) the previously held idea of reality (which usually has no place for such entities) and topple the experiencer from the sense of being a member of a uniquely intelligent life form at the peak of the Great Chain of Being. In the face of forces beyond their control, abductees are confronted with their helplessness and with the existence of intelligent beings possessing technologies and other powers far in advance of our own. They have access to what in Western societies is called non-ordinary states of consciousness, similar to the symbolic worlds of the shamans of indigenous cultures. They become aware of the great archetypes of the collective unconscious, a birth, death, and rebirth, which helps them to experience the connectedness to other beings and to the Creator or Source. (Mack, 1999, p. 277)

In this sense, Mack sees many of those claiming to have UFO and extraterrestrial experiences as also taking part in what fellow psychiatrist Stanislav Grof called the experience of a "spiritual emergence," which if not supported and sensitively worked with by professionals, can become an experience of "spiritual emergency." As Mack puts it, "*this awakening, the heightened awareness that grows out of the ego shattering impact of the encounters, carries with it quite consistently certain interrelated psychospiritual changes*" and this is the case "especially if the experiencers are enabled to work through the traumatic dimension of what they feel certain has happened to them" (Mack, 1999, p. 277).

For Mack, "*the cosmos that is revealed by this opening of consciousness, far from being an empty place of dead matter and energy, appears to be filled with beings, creatures, spirits, intelligences, god... The idea that we live in a multidimensional universe populated by beings or life forms that are less densely embodied than we are, or perhaps not embodied at all*" (Mack, 1999, p. 269). So, imagine if you are having such an overwhelming combination of UFO/ET and spiritual emergence or emergency experience, that this could have both short and long-term traumatic, unsettling, even destabilizing effects on the psyche of the experiencer.

In addition to his own clients and research subjects, Mack seems to have also experienced profound changes in his own psychological composition and worldview as a result of working in relation to this seemingly larger reality:

> "*I have come to see that the abduction phenomenon has important philosophical, spiritual, and social implications. Above all, more than any other research I have undertaken, this work has led me to challenge the prevailing worldview or consensus reality which I had grown up believing and has always applied to my clinical/scientific endeavors... What the abduction phenomenon has led me (I would now say inevitably), to see is that we participate in a universe or universes that are filled with intelligences from which we have cut ourselves off, having lost the senses by which we might know them*." (Mack, 1994, p. 3)

In the 2003 scholarly book, *UFO Religions,* in his chapter, the Psychology of UFO Phenomena, John Saliba, a graduate of Oxford University and an authority on religious studies and new religious movements, writes:

> *"There seems to be agreement that, no matter what theory of UFO encounters one accepts, many UFO experiences, particularly those that include abduction, created serious personal problems for the abductee, problems like posttraumatic stress disorder, that require therapeutic intervention. The therapy proposed, however, is usually based on one of the following theoretical assumptions. The first starts with the view that UFOs do not exist and that consequently encounters with them are indicative of serious pathology... The second assumes that those who relate UFO experiences, including abductions, are telling the truth. The trauma of real UFO encounters often results in pathological symptoms that require treatment. In this case, UFO encounters precede pathology".* (p. 337, Saliba, in Partridge, 2003)

Jodi Dean, assistant professor of political science at Hobart and William Smith colleges, has taken an interest in a sociological as well as political dimension to those associated with UFOs and extraterrestrials. In her book, published by Cornell University Press, *Aliens in America: Conspiracy Cultures From Outer Space To Cyberspace*, she writes:

"Ufology is political because it is stigmatized. To claim to have seen a UFO, to have been abducted by aliens, or even to believe those who say they have is a political act. It might not be a very big or revolutionary political act, but it contests the status quo. Immediately it installs the claimant at the margins of the social... What some people believe UFOs are real and true affect our concepts of politics and the political... My particular interest is in those, like ufology and abduction, that not only turn on questions of evidence, but involve charges of conspiracy and are in conflict with what is claimed as "consensus reality" or "common sense."...It is not that UFO believers are irrational. Rather, being unable to judge their rationality points to the lack of widespread criteria for judgments about what is reasonable and what is not." (Dean, 1998, pp. 6-9)

From Exceptional Human Experiences, to Questionable Deviance, to Possible Psychopathology: A Spectrum

Throughout this chapter, references have been made regarding the possibly questionable cognitive, emotional, and behavioral capacity to adapt to and function within the dominant consensus reality on the part of those comprising our proposed new category of diversity: those associated with the anomalous and paranormal. The following section presents a suggested spectrum for us to use, ranging from psychopathology on one end, to normative, healthy and functional states and conditions in the middle, to kinds of high or optimal performance and giftedness, on the other end. This is actually more of a Bell curve than a linear spectrum, since the main, most populated "hump" of this distribution curve is comprised of individuals who would be considered normal, well-adjusted, functioning and well adapted to the consensus reality, who just happen to be presenting with anomalous or paranormal characteristics; while the two "tails" of the curve are populated with a minority of those associated with negative and unwanted deviance from the norm, on one end, and a minority of those associated with positive even desirable deviance from the norm, on the other end.

While the following study deals with only the extraterrestrial encounter type of the six anomalous and paranormal kinds of experience earlier presented, studies like it have been done with subjects representing most of the other five categories as well. This particular correlational study was published in the journal *Science by* Nicholas Spanos et al. of Carlton University, Ottawa, Canada. The study compared 49 subjects who claimed to have seen UFOs and 127 who did not. All were tested for IQ, mental stability, fantasy proneness, hypnotizability, and their belief in the paranormal. Of these five areas tested, the only one in which those who claimed to see or experience a UFO differed from non-experiencers was in their belief in the existence of UFOs. That is, as is shown in this

research and in numerous other similar studies since then, those claiming UFO/ET experiences and beliefs appear psychologically to be normal and functional and only differ from other people insofar as they have had such unusual experiences and beliefs. Therefore, the long-standing and widely held association made between those reporting anomalous and paranormal experiences and beliefs, including those involving UFOs and extraterrestrials, on the one hand, and questionable mental health and instability, on the other hand, is proving to be an inaccurate and unfortunate presupposition. Nonetheless, there will always be some such experiencers and believers for whom some kind of psychopathology or personality disorder may, in fact, be the case (Spanos et al., 1993).

Prof. John Saliba, author of *Perspectives on new religious movements,* reminds us that "*the conclusion that many psychologists draw from current studies is that those who have had UFO experiences, including abduction ones, are as a rule average, ordinary individuals who do not exhibit pathology and who therefore cannot be classified as paranoid or schizoid*" (Saliba, 2003, p. 336). He also concurs with many others that "*the main task of psychology [is] not to determine whether encounters with UFOs and their alien inhabitants are based on the real presence of visitations from other galaxies. Rather psychologists and psychiatrists are concerned with helping those whose experiences have had a negative effect on their mental, psychological, and social functioning*" (Saliba, 2003, p. 339). In this regard, it is interesting to note that often it is not that having had an anomalous experience or belief is what has such a negative effect on someone, but, rather that it is the skeptical, disbelieving, adversarial, even psychopathologizing attitude on the part of others, including helping professionals, that is what can lead to having such a negative effect.

How, then, do we see and treat those individuals who's experiences, beliefs, and understandings differ from the norms defined by the consensus reality and the scientific establishment? Do we consider them just different, eccentric, statistically deviant with respect to most people's experiences and beliefs, but otherwise being acceptable members of our human family? Or might we consider them abnormal or disordered in some way because of the degree to which they diverge from the dominant order of experiences, beliefs, and understandings, with regard to their way of being in the world-- how they see, and behave within, the world?

The mental health profession, comprised of psychologists, psychiatrists, and counselors, has become the authority that evaluates how well and to what degree the individual fits, and conforms to, the consensually accepted order and truth of things. It is the role and responsibility of these professionals to assess how *functional* the individual is within a world in which there is unequivocally a dominant system of scientific understanding that is materialist and a day-to-day overwhelmingly dominant consensus reality that we share. If such functionality is professionally questioned regarding an

individual, that individual may be labeled as *dysfunctional*. If his or her ability to sufficiently *adapt* to the world in terms of how our dominant science construes it becomes professionally questionable, and if his or her understandings and beliefs, and the behaviors stemming from them, are professionally, even clinically, questionable, then the individual may be seen as *maladaptive.*

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (2013) considers the two realms of what it terms *internalizing* and *externalizing* factors in considering an individual's functionality and adaptive capacity: "The externalizing group [includes] disorders exhibiting antisocial behaviors, conduct disturbances, addictions, and impulse control disorders" (DSM, 2013, p. 13) Clearly, these are the kinds of things that could draw attention to the individual and get him or her "in trouble". On the other hand, internalizing disorders "are characterized by depressed mood, anxiety, and related physiological and cognitive symptoms" (p.13), that it is possible for the individual to "get away with" due to their subtler expressive nature as experienced by others.

Given our focus population of those having and sharing their anomalous and paranormal experiences and behaviors of a variety of kinds, this chapter asks us to revisit and look more carefully at the contention that they, or some of them at least, qualify as having some kind of mental disorder in the eyes of the mental health profession.

In the new DSM-5 (2013), the following definition for mental disorder is provided:

> *a mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects the dysfunction in the psychological, biological, or developmental processes underlying mental function. Mental disturbances are usually associated with significant distress or disability in social, occupational, or other important activities.* (DSM-5, 2013, p. 20)

Research has shown that most individuals presenting with anomalous and paranormal experiences and beliefs should not be placed in this category of possessing a mental disorder. Additionally, the *DSM-5* points out that, "socially deviant behaviors (e.g., political, religious, or sexual [*and anomalous or paranormal could also be added*]) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results in the dysfunction in the individual" (DSM-5, 2013, p. 20). Still, consider the distinction between a "deviance or conflict resulting in the dysfunction <u>in</u> the individual" and a "deviance or conflict resulting <u>from</u> a dysfunction in the individual".

Again, from the *DSM-5:* "Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis" (p. 14). Therefore, diagnostic assessment must "consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaption in the culture of origin" (p.14). Furthermore, "Thresholds for tolerance for specific symptoms or behaviors differ across cultures, societies, and families", Therefore, "The judgment that a given behavior is abnormal or requires clinical attention depends on cultural norms that are internalized by the individual and applied by others around him" (p. 14).

Who can become a candidate for having anomalous or paranormal experiences and beliefs? There seems to be a constellation of characteristics that are related to them that have already been mentioned, including: absorption, hypnotizability, dissociative tendencies, fantasy proneness, occasional deficits in reality testing, possible schizotypal personality disorder symptoms, the capacity to enter altered and higher states of consciousness, idiosyncratic spiritual experiences, openness to experience, high creativity, and transliminality. However, most of these need not require intervention from the mental health community, that is unless sought by the individual.

Such individuals are disposed to respond positively to some of the subscales of The Anomalous Experiences Inventory (AEI), such as "being able to communicate with supernatural forces," or having "experienced other planes of existence beyond the physical," or having "met an extraterrestrial," as earlier mentioned. Becoming drawn under the diagnostic lens of the clinician, many who present with such anomalous and paranormal experiences and beliefs can become candidates for being labeled with dissociative identity disorder and schizophrenia spectrum disorders, including schizophrenia, schizotypal personality disorder, delusional disorder, and brief psychotic disorder, among other clinical conditions. Many of these diagnostic categories include having the criteria of delusions and hallucinations. But, the DSM-5 reminds us that "In culture-related diagnostic issues, cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and social economic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another" (DSM-5, p. 103).

Anomalous and paranormal experiences have often been associated with delusions or hallucinations, where the individual in question is considered to be having an entirely private kind of experience, very real to him or her, but unavailable to others and unable to be corroborated by them, recalling the saying that "it is all in his head," leading to the proclivity to psychopathologize. In the DSM-5, the first two of the five diagnostic characteristics that can be indicative of schizophrenia include delusions and

hallucinations; In Brief Psychotic Disorder, the first two of the four diagnostic criteria are also delusions and hallucinations. Schizotypal Personality Disorder, the DSM-5 category that seems most related to anomalous and paranormal experiences and beliefs, is indicated by five or more of the following characteristics:

1. Ideas of reference (excluding delusions of reference).

2. Beliefs or magical thinking that influences behavior and is consistent with subcultural norms (e,g,, superstitious must, belief in clairvoyance, telepathy, or 'sixth sense; in children and adolescents, bizarre fantasies or preoccupations).

3. Unusual perceptual experiences, including bodily illusions.

4. Odd thinking and speech

5. Suspicious or paranoid ideation. (DSM-5, 2013, p. 655)

Anneli Goulding, Senior Lecturer in the psychology department at Gothenburg University, Sweden, reminds us that "A person can show signs of schizotypal personality without having a mental disorder" (Goulding, 2000, p. 50). As was just pointed out, Schizotypal Personality Disorder has symptoms potentially relatable to certain experiential characteristics of anomalous and paranormal experiences and beliefs.

In the DSM-5's Glossary of Technical Terms, "psychoticism" is designated as one of the five personality domains, and is seen as "exhibiting a wide range of culturally incongruent, odd, eccentric, or unusual behaviors and cognitions, including both process (e.g., perception , dissociation) and contact (e.g., beliefs)". Other aspects of psychoticism, according to the DSM-5, include unusual beliefs and experiences; for example,, "belief that one has unusual abilities, such as mind reading, telekinesis, or thought-action fusion; unusual experiences of reality, including hallucinatory experiences. In general, the unusual beliefs are not held at the same level of convictions as delusions." There is cognitive and perceptual dysregulation, involving "odd or unusual thought processes and experiences, including depersonalization, derealization, and dissociation; mixed sleep-wake state experiences; and thought-control experiences." Eccentricity includes "odd, unusual, or bizarre behavior, appearance, and/or speech having strange and unpredictable thoughts; saying unusual or inappropriate things." One can present with a delusion, defined as "a false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious evidence to the contrary," or a bizarre

delusion, "that involves a phenomenon that the person's culture would regard as physically impossible." There is hallucination, which is "a perception-like experience with the clarity and impact of a true perception but without the external stimulation of the relevant sensory organ." One can have ideas of reference: "the feeling that causal incidents and external events have a particular and unusual meaning that is specific to the person." And one can have an "overvalued idea," defined as "an unreasonable and sustained belief that is maintained with less than delusional intensity [and where] the belief is not one that is ordinarily accepted by other members of the person's culture or subculture" (DSM-5, 2013).

In spite of the disposition of many in the mental health profession to continue to psychopathologize individuals who would differ from the norm in certain beliefs and experiences, psychiatrist John Nelson speaks for those in the profession who have other views of clients who are different. He writes that psychosis-related attributions need not necessarily be medical disorders, but may be “a fiction invented by authorities determined to suppress anti-technological thinking and nonconformists lifestyles. In this view, the diagnosis creates the disease” (Nelson,1994, p. 30). He points to pioneering fellow “antipsychiatry” psychiatrist Thomas Szasz, who argues that psychiatric diagnoses are political terms based on entrenched social prejudice. But Szasz is unique in his view that mental illness is not a physical disease, or even a socially induced disorder, but a myth… People are held in mental hospitals for the sole reason that they are subversive to the social order. Psychiatrists are *mind police.* (Nelson, 1994, p. 81)

Clearly, those professionals holding this perspective would interact with and try to help an individual with potentially psychotic-seeming anomalous and paranormal experiences and beliefs in ways different from the majority of fellow mental health professionals who do not hold this perspective.

With regard to things anomalous and paranormal , the following could be considered more related to the main, normative hump of the bell curve and even extending over to the more positive or desirable tail of the curve:
Exceptional Human Experiences (EHEs). The category of *exceptional human experiences* was created by researcher Rhea White, publisher of Parapsychological Abstracts International, editor of the Journal of American Society for Psychical Research, and president of the Parapsychological Association, the international society of professional psychologists. As part of her work, The Exceptional Human Experience Network, Inc. (EHEN) was created as an educational and research organization to study a variety of kinds of anomalous experiences, with White defining the anomalous as simply that which is out of the ordinary. According to White and her network, because these anomalous experiences "are primarily subjective, scientists tend to ignore them. They do

not fit into today's scientific theory, and our culture typically does not have a way to understand and deal with them." Furthermore, "People who have these types of experiences are often not believed, or are considered odd or strange." Yet, for White and her colleagues, "such experiences are potential starting points for positive, personal, life-enriching, life-changing growth." Then, "by valuing these experiences in new ways, and sharing them (even anonymously) with other experiencers, we all gain meaningful insights into ourselves and our world" (http://www.ehe.org; retrieved 4/2/14). So, by reconsidering things that are generally construed as anomalous and paranormal, and even being associated with clinically questionable psycho-emotional and behavioral states, when calling them "exceptional human experiences," as White does, although they deviate from the norm, they may be placed more on the positive, than the negative, end of the psychological spectrum.

We find subtle differentiations in the literature across related terms such as paranormal, anomalous, exceptional, and non-ordinary. Johan Gerding, Director of the Parapsychology Institute in Utrecht, and Chair of Metaphysics at Leiden University's Institute of Philosophy, both in the Netherlands, specializes in philosophical issues that relate to the content of anomalous experiences. He writes, "A strictly paranormal aspect is often just one element of an exceptional experience. An out-of-body experience, for instance, is exceptional, but it should not be considered 'paranormal' in any strict sense without verifiable data (i.e., the out-of- body experience should encompass information to which the experiencer had no possible normal sensory access). Exceptional experiences usually cannot be reduced to the elements that might be described as paranormal" (Gerding, 2012, p.105). Still, an ambivalence can remain across psychologists and mental health professionals regarding different kinds of exceptional experiences. Gerding writes, "Not surprisingly, therefore, most health-care professionals tend to either ignore transcendent and paranormal aspects of reported exceptional experiences or, worse, they are inclined to interpret these elements within the framework of pathological diagnoses" (Eybrechts & Gerding, 2012, p. 35).

Psi-Related Experiences (PREs)

We return briefly to our earlier-discussed domain of psychic (psi) or parapsychological experiences and beliefs, looking at them now particularly as they might be placed variously across our high-functional to normal to dysfunctional spectrum or Bell curve, depending on who may be doing such placing and on what basis.

Psychiatrist Giovanni Iannuzzo, founder and director of the Center of Behavioral Sciences, Clinical Psychiatry and Mental Hygiene at the University of Messina (Italy), specializes in the relationship between psi phenomena and mental disorders. He observes that "The individual who has experienced psi phenomenon generally functions perfectly well within his community. He has no major problems with coping and, therefore, is

perceived as quite 'normal.' The mentally ill person may or may not perceive himself as ill-- if he does not (and this frequently happens in the psychotic, who by definition is out of touch with reality), his culture generally does" (Iannuzzo, 2012, p. 60).

Parapsychologist Russell Targ and his colleagues warn that "*Overreliance on reported PREs [psi-related experiences] to diagnose schizotypal personality disorder or schizophrenia, for example, carries the substantial clinical risk of stigmatizing, alienating, or even erroneously medicating an individual. The risk of such misdiagnosis may be particularly high in circumstances in which patients are struggling to integrate PREs in the absence of guidance or reliable information. Some individuals claimed that they had avoided or left the mental health system because they correctly recognize that many counselors and psychotherapist are not well-informed about the phenomenology of PREs.*" (Targ et al., 2000, p. 233).

They add, "the 'pathological' label does not characterize the majority of experients" (Targ, Schlitz, & Irwin, 2000. p. 239); though they point out that "We emphasize the need and difficulty for the clinician, treating a client who has undergone these experiences [e.g. PREs], to make a diagnosis and offer appropriate treatment, usually in the context of having no means of ascertaining the veridicality of the experience, let alone its panormality" (Targ et al., 2000, p. 221).

In his book, *Healing the split: Integrating spirit into our understanding of the mentally ill, Revised edition*, psychiatrist John E. Nelson defines psychosis as "one of several altered states of consciousness, transient or persistent, that prevent integration of sensory or extrasensory data into reality models accepted by the broad consensus of society, and that leads to maladaptive behavior and social sanctions." However, he warns that, "To the confusion of many, this definition also describes several potentially *adaptive* altered states of consciousness (ASCs)" Therefore, "Our failure to distinguish between malignant and benign psychotic ASCs in terms of cause, degree of progression, adaptive value, potential for spiritual growth, and treatment strategies bedevils both mainstream psychiatry and alternative schools of thought" (Nelson, 1994, pp. 3-4).

The term "peculiar" tends to carry a less stigmatizing meaning, and may more easily fit mainstream normality, then the terms anomalous or paranormal. It also has more of the quality of the exceptional than the deviant. Something that is peculiar has a kind of exclusive quality, something that is out of the ordinary, which may or may not be a problem for others. In that something peculiar belongs distinctly to a person, it could be construed as positive and desirable or as negative and criticized, depending on the primary culture or on the aforementioned culture-of-one of the individual doing the construing. University of Illinois psychology professor Howard Berenbaum and his

associates write, "Peculiarity is a multidimensional individual-differences variable. Individuals differ in the degree to which they have peculiar sensory impressions, have peculiar experiences or hold peculiar beliefs." The relationship between beliefs and experiences may differ: "An individual may hold peculiar beliefs but never have peculiar experiences. Conversely, an individual may have a peculiar experience but not endorse any peculiar belief. At the high end of the continuum, peculiar beliefs are considered delusional, and particular perceptions are considered hallucinations″ (Berenbaum et al., 2000, p. 27.

Developing guidelines for working with individuals falling under our proposed new protected category of diversity can help expand our understanding of and appreciation for the contributions that may be able to be made to our science and culture at large by those possessing vision, creativity and originality. The larger spectrum we have been considering contains its own smaller ones at every turn. For example, there is healthy openness to experience and to the varieties of kinds of experience and a disposition toward transliminality and what may be tapped from what Huxley called 'Mind-at-Large, on one end, and a potentially problematic, but not necessarily pathological, fantasy proneness and schizotypal tendencies, on the other end.

This chapter has been advocating a constructivist, postmodern pluralistic and as well as culture-specific view of what is considered real or true, and acceptable as such. This reflects cultural diversity's tolerance for and understanding of the varieties of 'the other,' and an increasing openness to and acceptance of what is considered exceptional, peculiar, and scientifically anomalous on the part of mainstream psychological theory and practice.

Psychiatrists Parnas and Handest speak of what they call "the metaphysical quest" available to all of us, and which calls more strongly to some than to others. Like the mythical sirens wooing sailors to become shipwrecked on the rocks, many of us are wooed to personal adventures involving altered and higher states of consciousness and expanded, chance-taking excursions into experientially peculiar and scientifically anomalous realms of alternative reality and of Mind-at-Large. They write of "young pre-schizophrenic patients [who] become excessively preoccupied with philosophical, supernatural, and metaphysical themes." They remind us that "the search for transcendent meaning (i.e., metaphysical quest) is of course not restricted to schizophrenia but is the distinctive and pervasive characteristic of all human thought," and they speak of anomalies of experience "involving the subjectivization of the world, disembodiment, and instability of the self, [that can] shatter the experiential equilibrium normally characteristic of the 'basic relation' and intensifies the metaphysical quest" (Parnas & Handest, 2003, p. 130). Once more, we are returned to psychiatrist Stanislav Grof's concept of 'spiritual emergence' and, at times, of 'spiritual emergency', comprising one of our six earlier mentioned anomalous and paranormal domains.

Clearly, non-normative exceptional human experiences of a variety of kinds can all too quickly fall prey to becoming rendered psychopathological under the diagnostic lens of the medical and mental health professions. Take just one of thousands of examples: In their case study, "Transforming extraordinary experiences into the concept of schizophrenia: A case study of a Norwegian psychiatric unit," Terkelsen et al. (2005) trace how what from one frame of reference might be considered a relatively healthy condition of schizotypy and an acceptable, functional exceptional experience of an anomalous or paranormal kind, can quickly become clinically pathologized and institutionalized. The authors speak of how in the process "the asymmetry of power between the professionals' and Tom's [the patient's] theory of knowledge is evident. The fundamental disregard for Tom's [the patient's] and other patients' extraordinary beliefs emerged" (Terkelsen, 2005, p. 247). The authors point out that

> *"There has been a shift from a psychological approach to the treatment of such experiences to a biomedical framework, with medication and medicine compliance. Patients diagnosed with schizophrenia often tell about extraordinary experiences, such as encounters with UFOs and angels... We explore the translation, transformation and transition of such experiences in the psychiatric terminology based upon biomedical knowledge and understanding and how a patient in a psychiatric rehabilitation unit explains and interprets his extraordinary experiences, [and] how he perceives the manner in which his experiences are confronted by professionals."* (Terkelsen et al., 2005, p. 229)

Dissociative Identity Disorder

Dissociative Identity Disorder is another diagnostic category used by the mental health profession that may have some relationship with the spectrum from healthy and functional to psychopathological and dysfunctional with anomalous and paranormal experience. The chief diagnostic criterion for Dissociative Identity Disorder is "Disruption of identity characterized by two or more distinct personalities states which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations and affect, behavior, consciousness, memory, perception, cognition, and/or sensorimotor functioning. These signs and symptoms may be observed by others or reported by the individual" (DSM-V, 2013, p. 292). As Targ et al. point out, "Patients with dissociative tendencies, actively pursuing guided imagery or hypnosis, may report confusing experiences in which they feel they are receiving information from outside sources but that may in fact represent intense imaginary events" (Targ et al., 2000, p. 229). Yet, as has been often pointed out in this chapter, Western science, including psychology, still seems far from being able to conclusively ascertain where, on a spectrum ranging from completely inner and subjective on the one hand to completely external and objectively real on the other, the locus of many anomalous and paranormal experiences and beliefs may ultimately lie.

Hearing Voices

One exceptional human experience, and the beliefs about it, that has been reported for thousands of years involves individuals hearing voices for which there seems to be no external stimulus at the time. "Hearing voices is still considered by clinicians as auditory hallucinations that are a symptom of conditions such as schizophrenia," but "there are life experiences in which hearing voices is considered normal, such as bereavement… For several years, a social movement lobbying for hearing voices to be treated as a normal phenomenon has been growing" (Stip & Letourneau, 2008).

Concluding this section's use of a spectrum or bell curve across which to distribute the anomalous and paranormal-- *From Exceptional Human Experiences, to Questionable Deviance, to Possible Psychopathology: A Spectrum*-- psychiatrist Mitchell B. Liester has studied a variety of kinds of what he calls "inner voice" experiences, dividing them between "transcendent" ones associated with health, high function, and valuable spiritual emergence, and those that are pathological. He writes:

> *Despite such evidence linking inner voices with pathology, equally compelling evidence demonstrates their occurrence in the absence of pathology… In many cultures, voices continued to be valued as a source of trans-rational assistance... The belief that transformations are the products of psychotic symptoms belies an ethnocentric worldview. A more plausible explanation is that these helpful inner voices belong to a separate category of experiences, those which have the potential to facilitate growth in the individual, on either personal, and societal levels… Psychology, which is so often guilty of pathologizing inner voices, has nonetheless been deeply affected by them. Several of the field's most influential figures heard, and were influenced by inner voices. Carl Jung, who held conversations with an inner voice throughout his life. Many similarities exist between pathological and transcendent inner voices. First, both are heard with the mind, not ears. This makes it impossible for others, who cannot hear the voices, to corroborate their content or even their existence… Second, both kinds of voices may appear to have an outside origin…A continuum of inner voices exists which includes both hallucinations and revelations. Despite our culture's ego-retentive tendency to view intuitive and revelatory inner voices as 'unreal', or even worse as symptoms of pathology, these voices are a powerful, influential force in our world. They can offer inspiration, guidance, and intuitive knowledge to those willing to listen. Transcendent inner voices should not be labeled 'hallucinations.'... We can no longer afford to ignore, discount, or apologize for transcendent inner voices. The future survival of our species and our planet hinges upon our ability to access and utilize creative new solutions to global problems. Transcendent inner voices can provide a link to the transpersonal realms of consciousness where, perhaps, solutions to these problems may be found.*
> (Liester, 1996, pp. 3, 15, 21, 25, 26).

Suggested Ways of Working With Those in This New Category of Diversity

1) Rogerian person-centered therapy. Practicing Carl Rogers' triad of having nonjudgmental, unconditional positive regard for the client, the clinician's own congruency or genuineness, and having empathic understanding for the client, is perhaps the best single approach to take when working with someone who's experiences and beliefs are of an anomalous or paranormal nature sufficiently different from the clinician's own and from the dominant consensus reality to pose a problem or challenge for the clinician seeking to help the client adapt to and survive functionally within the embedding consensus reality (Rogers, 1951; Rogers, 1957). From Rogers' person-centered or client-centered perspective, the goal of the clinician is not to help clients to divest themselves of their worldview, values, experiences and beliefs simply because they may prove markedly different from the clinician's or the dominant norms (even those of the dominant scientific paradigm). Mather, the clinician's role is to work to understand and support, and to positively regard and empathize with, the client's own unique culture-of-one and to help him or her adapt to and optimally function within the surrounding consensus reality without having to "throw the baby out with the bathwater" by helping the individual to be rid of what made him or her unique in order to become acceptable by fitting within the surrounding norms.

Related to the approach of Rogers, can be using another humanistic approach, existential psychotherapy and counseling, to encourage the sharing and clarification of the client's experience and worldview and to relate it to the dominant consensus reality and helping him or her to cope with the 'existential givens.' Also, clinicians and counselors can adapt phenomenological and existential research methodology to draw out in depth and better understand, for both client and clinician, the client's unusual experiences and beliefs.

Related to both person-centered and existential humanistic approaches, extraterrestrial encounter researcher and Harvard psychiatrist John Mack addresses helping those with troubling extraterrestrial and otherworldly experiences. As with so many other researchers and clinicians, Mack points out that "psychological testing of abductees has not revealed evidence of mental or emotional disturbance that could account for the reported experiences." On the contrary, many of the *"experiencers are highly functioning individuals who seem mainly to need support in integrating their abduction experiences with the rest of their lives. Others verge on being overwhelmed by the traumatic impact and philosophical implications of their experiences and need a great deal of counseling and emotional support"* (Mack 1994, p. 15).

2) Providing the individual with the potentially healing experience of really feeling understood. This approach is drawn from Dutch priest and psychologist Adrian Van Kaam's 1951 dissertation, "The experience of really feeling understood by a person." To have one's personal story, experience, way of seeing and being in the world, one's core values and cognitions, really feel understood by someone, no matter how anomalous and paranormal others might consider such, can truly feel like a liberating gift to that person. This seems to be the epitome of Rogers' "empathic understanding," and when combined with his "unconditional positive regard," can move from empathy to compassion, from the head to the heart. When someone can experience true compassion being felt for them by another, this can be a very important way to unlock the shut up or stuck heart and mind. It is a deeply natural and human approach that can work where most other rehearsed clinical and counseling tools and techniques might not work.

3) The therapist operating as a kind of neo-shaman capable of temporarily joining with the client in his experiences and beliefs. Recall Charles Tart's early-mentioned concept of "state-specific science," which may be conducted where two or more scientists or researchers can share a similar-enough altered state of consciousness that they can conduct experiments and share information with each other while temporarily comprising their own small-n consensus reality different from the much-larger surrounding one (Tart, 1975, pp. 206-228). In this sense, it is possible that a clinician or counselor might, somewhat in the manner of the innovative Scottish psychiatrist R.D. Laing, be able to temporarily alter his or her consciousness, as shamans are known to be able to do in other cultures. This would be done in order to more closely align with and even enter the state of consciousness of the client, thus allowing a kind of transient two-person contact, communication, and understanding on a more shared wave-length. Also, traditionally, shamans are characterized as being able to move at will between the dominant physically-based consensus reality and various nonphysical or transcendent realms, and to be able to do this to provide a service to others in the dominant culture unable to alter consciousness and move between experiential realms in this manner.

Similarly, Walsh and Vaughan's earlier-mentioned state-specific-type perspective on altered states of consciousness considers that if "each state of consciousness reveals its own picture of reality, it follows that reality as we know it (and that is the only way we know it) is also only relatively real. Put another way, psychosis is attachment to any one reality" (Walsh & Vaughan, 1980, pp. 54-55). If so, it may be possible for the clinician and client to find state -specific modes of access into and out of the client's potentially dysfunctional isolated states of consciousness in order to help him share his lived experience and to better function adaptively within the dominant consensus reality without having to relinquish what makes him different and special.

4) Using a multiculturally informed kind of cognitive behavioral therapy. Here the task is to help the individual try to get to the heart of, and identify, her thoughts, beliefs, cognitions, and personal worldview characterized by her anomalous and paranormal experiences and beliefs. If the underlying cognitions in turn contribute to the individual's emotions and feelings, especially negative or maladaptive ones, and contribute to behaviors unwanted by either the individual or the surrounding society, then the challenge involved is to work with the beliefs and cognitions that underlie the emotions and behaviors. When the beliefs and cognitions of the individual are non-normative and construed by others as deviant and unwanted, the question becomes how to help the individual monitor and manage his thinking, emotions, and behaviors within a dominant consensus reality whose beliefs and cognitions, including its core scientific ones, are not the same as the individual's. Therefore, most others' emotional states and behaviors, as well as their beliefs and understandings, will not be congruent with the individual in question. The individual's culture-of-one, due to its strong anomalistic and paranormal nature, is in conflict with the dominant culture and with members of the surrounding consensus reality. The role of the helping professional then, it would seem, is to help the individual with his or her idiosyncratic beliefs, cognitions, and experiences as they relate to the ensuing emotions and behaviors irrevocably embedded in the consensus reality sufficiently different from the individual's. Helping individuals comprising this new category of diversity characterized by anomalous and paranormal experiences and beliefs will require developing an interpersonal and multiculturally oriented kind of cognitive behavioral therapy that will need to balance both the minority rights and interests of the individual's culture-of-one, on the one hand, and those of dominant culture, on the other.

5) Variations on the foregoing. Person-based cognitive therapy (PBCT), mindfulness-based cognitive therapy (MBCT), acceptance and commitment therapy (ACT), and narrative therapy can all provide ways to help individuals characterized by the anomalous and paranormal to, in the words of this chapter's title, work toward "the care and preservation of [their] private experience and belief in a public and scientific world." Using mindfulness, for example, to potentially effect the intersubjectivity in the therapy room, when the therapist is able to introduce a meditative and insightful ASC to help model and entrain this in the client, can enhance intuition, insight, relating, and resonance in the therapeutic alliance.

6) Helping clients bridge between their anomalous experiential world and the consensus reality, but not necessarily to abandon their own anomalous experiences and beliefs. Also, providing help with reality testing. Even though this approach can be part of all the others on this list, it is good to separate it out specifically this way. The idiosyncratic culture-of-one of the individual and the larger normative conforming consensus reality constitute two aspects of a kind of bicultural situation. It is possible to

help the individual, and help the individual help himself, to successfully co-dwell in both of these experiential and cognitive domains at the same time. Recall William James' advocacy of the pluralism of different states of consciousness and the experiences state specifically available by means of them: "There live potential forms of consciousness entirely different [from the norm]" and that "no account of the universe in its totality is final which leaves these other forms of consciousness quite disregarded" (James, 1902).

7) Helping clients find meaning in what they are experiencing through adapting Frankl's logotherapy. An argument can be made that most of us might be able to gain both personally and professionally from working with someone trained in Frankl's logotherapy approach, or to study that approach on our own and apply it to ourselves, even as Frankl did for himself so that he could then turn to work with others in a similar manner. If most normative people could benefit from working to find the meaning in, or greater meaning in, their own lives or some aspect of it, imagine how useful the search for personal meaning in one's life could be for someone having to deal with possibly problematic or disturbing anomalous or paranormal experiences and beliefs for which the mental health profession may too often only be able to find meaning with regard to uselessness and deviance, even maladaptiveness and dysfunction.

8) Using bibliotherapy and psychoeducation, prescribing readings and non-clinical referrals regarding "new science" (e.g. holographic and quantum physics concepts, incl. 'non-locality'), parapsychology, consciousness studies, transpersonal studies, cross-cultural studies, and UFOlogy and Extraterrestriology, to name just some areas of personal study that could shed light for the individual on his/her perplexing, even disturbing, anomalous or paranormal experiences and beliefs. Such bibliotherapy and psychoeducation study is recommended for the clinician and helping professional, as well as for the client, in order to establish an effective multiculturally informed common ground of understanding.

9) Helping with individuals' spiritual emergence experience. Contacting and using the services of the Spiritual Emergence Network (http://spiritualemergence.info/spiritual) or the Spiritual Emergence Service (http://spiritualemergence.net/) are just two examples, in addition to reading some of the books already published on this topic. The helping professionals at the Spiritual Emergence Service answer the question of 'what is Spiritual Emergence?' in the following way:

> *The term Spiritual Emergence has been used to refer to the awakening of the spiritual potential within an individual that initiates the unfolding and expansion of that individual's way of being...When this process occurs rapidly or becomes very intense it can seem disruptive and out of context with everyday life, precipitating a personal crisis which is referred to as a Spiritual Emergency....Spiritual Emergence has the dual nature of being potentially deeply healing as well as potentially deeply disturbing. When those experiencing disturbed manifestations of SE [spiritual emergence] seek traditional health care, they may feel misunderstood or be diagnosed as emotionally disturbed and prescribed medication or other medical interventions. The healing potential of the emerging spirit is often distorted or smothered and the aim of symptom management becomes the goal of therapy.* (Spiritual Emergence Service; http://spiritualemergence.net/; accessed 3/26/14)

In the case of the "domain of spiritual or transpersonal experiences, beliefs and practices" comprising one of the earlier-presented "Six components comprising the new diversity category," it is very important how the individual going through such a spiritual emergence is seen and worked with by members of the mental health profession. Too often, the emergence can turn into an emergency due to ignorance, misunderstanding, insensitivity, or automatic psychopathologizing on the part of the professional working with that individual. In this regard, it is useful to read once more that, "The assertion has appeared repeatedly in the literature that it is unethical for counselors to provide clinical services to clients who are culturally different from themselves if the counselor is not competent to work effectively with these clients" (Watson et al., 2006, p.1). It is suggested that clinicians can gain this competence to work effectively with such clients when informed and guided by using as many of the 11 suggested approaches as possible listed in this section, and especially the first four.

10) Helping individuals manage the psychosis-related construals and attributions being made about them by others, including clinicians. This can be done through a multicultural approach that can adapt and interrelate different cultural, experiential, and cognitive frames of reference in a relativistic manner, appreciating in the process how each frame, when adopted, like an altered state of consciousness, has its own state-specific way of meaning-making and valuing and its own indigenous opportunities for learning and growth. One aim in taking this multicultural approach would be to work with individuals to help them understand that the dominant, preferred diagnostic perspectives currently taken by the mental health profession regarding the anomalous and paranormal need not be the only ones taken, and may not even be the most accurate or appropriate. In the postmodern pluralism and relativism of rival

hypotheses, explanatory frames of reference, and diverse cultural perspectives, each of the earlier "Six components comprising the new diversity category" has its own rapidly developing research, published literature, and growing numbers of people having such experiences and beliefs. How some professionals may psychopathologize someone's paranormal or anomalous experiences or beliefs can be placed within a larger multicultural pluralistic context within which many perspectives would value and respect, rather than psychopathologize, the non-ordinary. One person's paranormal becomes another person's normal as understood within a different or more inclusive frame of reference and understanding. One person's seeming maladaptive cognition and behavior may become another person's highly adaptive optimal performance, as interpreted from the understanding of a larger reality or from the understanding of other realities.

11) Drawing upon the developing sub-field of 'Clinical Parapsychology.'

The author of this chapter was one of the first to define the emerging field of clinical parapsychology as "an emerging subfield within the fields of professional psychology and professional parapsychology which combines training in licensed counseling and clinical mental health care practice, on the one hand, and parapsychology and consciousness studies on the other. Today, there are very few people equally trained in both domains" (Klimo, 1998, p. 302).

Thanks to an increasing involvement in this area in the last 10 years, especially in Germany and the Netherlands, there are an increasing number of professionals trained in this area. Speaking of how such a professional can help those seeking the services of a clinical parapsychologist, Klimo writes,

> *Such a professional would then be optimally trained to help others who have been having-- or seem to be having-- paranormal, non-ordinary, or otherworldly experiences that are sufficiently unsettling, troubling, or curiosity provoking to move them to seek help of one kind or another. This help could come in the form of information, knowledge, and understanding; of support, therapy, and help in "making it stop," or, conversely, help in finding ways to develop it further for positive use for oneself and others; or help in conducting testing or research that might resolve the nature and ultimate reality of that which is responsible for the paranormal experiences and their presenting problems or challenges. The clinical parapsychologist would be able to help those experiencing this larger, questionable reality to cease their connection to it, if they so desire, returning to a more limited but safe-feeling reality, or to help them continue to operate with respect to the larger reality with greater understanding, comfort, and control, able to function successfully within the larger consensus reality. In addition, such a clinical parapsychologist might also be able to bring to the counseling,*

psychotherapeutic, clinical, healing setting some degree of his/her own psychic abilities developed as part of his/her educational training that could supplement, not replace, traditional diagnostic and treatment skills. (Klimo, 1998a)

To review, someone trained in the new area of clinical parapsychology would be able to effectively work with individuals having parapsychological-type anomalous or paranormal experiences and beliefs in the following ways:

- Provide psychotherapeutic and counseling support.
- Provide education, explanation, and informational resources.
- Provide referrals to researchers, laboratories, experts, psychics, healers, practitioners, and other experiencers.
- Function in a forensic psychology expert witness capacity.
- Administer psychological testing and other ways of evaluating levels of function, adaption, reality testing, diagnosis.
- Help the individual successfully live with his/her non-ordinary experiences, beliefs, or abilities.
- Conduct testing or research to adjudge the verdicality of claims made by the client.
- Function as an educational and consciousness-raising consultant to organizations, institutions, and the media regarding parapsychological experiences and beliefs.

(Klimo, 1998a)

Continuing this theme, psychologist, psychic researcher, and psychic, Keith Harary, suggests six categories to help us "to develop appropriate clinical strategies for assisting individuals to deal effectively with their reported psi experiences:"

- Those who reported a lifelong, or otherwise long-term, history of psi experiences that appear primarily to have a veridical basis.
- Those who reported short-term history of psi experiences, or only a single such experience, whose experiences appear primarily to have a veridical basis.
- Those who report either a long or short-term history of psi experiences, or only a single such experience, and whose experiences appear to represent a mixture of veridical and imaginative elements.
- Those who reported psi experiences primarily are of a fanciful or hallucinatory nature, but who do not appear to be suffering from any disabling psychological disturbance.
- Those who are suffering from a disabling psychological disorder, and whose reported psi experiences primarily are of a pathological nature.
- Those who are responding to the reported psi experiences of others.

(Harary, 1989)

Psychologist and California Institute of Transpersonal Psychology (now Sophia University) professor Arthur Hastings, in his article, "A counseling approach to parapsychological experience," writes that

> *there must be an initial presumption of the reality of psi on the part of the counselor. While any individual case is open to determination, the existence of parapsychological abilities and phenomena is assumed, at least so far as research evidence and clinical studies imply… Presuming the reality of psi does not mean that any specific case is assumed to be a case of psi, only that the operation of psi is a legitimate principle to apply where the knowledgeable counselor deems appropriate.* (Hastings, 1986, p. 61)

Hastings points out that, “to tell the difference between psi and imagination, one must reality test… The parapsychological counselor cannot accept the assurance of the client that the psi experience occurred, any more than the report of a client is an unbiased description of a family quarrel” (p. 62). Further, “the parapsychological counselor should have a knowledge of clinical psychology and parapsychology, and should understand how psychic experiences and pseudopsychic experiences interact with motives, needs, emotions, self-concept, belief systems, personality, and other psychological elements” (p. 62). Hastings adds that “Most studies of psi have shown little or no causal connection with psychosis, schizophrenia, or other psychopathology” (p. 63).

Finally, consider the protocol developed by Martine Busch and her colleagues at the Parapsychological Institute, in Utrecht, the Netherlands, that provides an excellent model for working with individuals who are seeking help with regard to their anomalous and paranormal experiences and beliefs. Within the counseling strategy of the Utrecht parapsychology Institute for clients with (alleged) psychic experiences, the following characteristics can be recognized.

1) Obligatory Written Account: Before being admitted to the counseling department, potential clients are obliged to send in a (type)written account, specifying their main questions and giving detailed descriptions of two of their experiences.

2) The Occurrence of the Reported Event is Not Questioned: Initially counseling is based on the reported experience. Questioning whether the reported events actually occurred is an inadequate response to the client's request for help.

3) Psi Exists as an Experience: Regardless of the type of psi reported, clients experience psi as something that just happens to them, existing as an experience rather than a phenomenon. This makes them feel insecure, anxious and defenseless.

4) Listening to Cope with Psychic Experiences: For many clients, learning to cope with their psi experiences is the main issue. Finding effective coping strategies requires an active role for the client, who often expresses the need to feel in control.

5) Providing a Frame of Reference: Counseling must provide the client with a general parapsychological frame of reference and a personal psychological context within which to place his/her experiences. Psi is neither stimulated nor repressed.

5a) Presenting "facts": Many consultations start with presenting "facts" about psychic phenomena: for example, "Many people have these experiences." "Having a precognitive dream doesn't mean that it happened just because you dreamed it." "It is not possible for your neighbor to influence your entire life psychically." "Being paranormally sensitive is not an excuse for unsatisfactory relationships." "OBEs [i.e., out-of-body experiences] can be induced by operations." Providing such clear and factual information can diminish anxiety and insecurity dramatically.

5b) Distinguishing True Psi from Pseudo Psi: We always attempt to help the client find ways to be critical of their own experiences and distinguish true psi from pseudo psi.

5c) Various Coping Strategies: Depending on their individual requests for help, clients are presented with specific strategies for dealing with both form and content of their experiences, the negative reactions from their environment, and related issues.

6) Linking Psi to the Client's Psychology: To facilitate the development of efficient coping strategies is beneficial to connect the knowledge about psi with the individual's perception of the events. It is always attempted to search for the meaning of experiences in terms of the client's own life. While psi is a general phenomenon, its content, form and occurrence at this time give clues to its specific meaning for the individual. Even if the person incorrectly attributes a paranormal meaning to an event, there may be a psychologically legitimate reason for him/her doing so.

Many clients have the experience that psychologists and psychiatrists don't believe them. They feel underestimated and misunderstood and consequently tend to over emphasize the paranormal component. Sometimes perspectives from transpersonal psychology are used to help the client find meaning in what he/she is experiencing. (Busch, 1995)

Conclusion

The purpose of this chapter has been to propose a new category of diversity-- of those with anomalous or paranormal experiences and beliefs-- to add to those familiar categories of diversity already accepted in the fields of professional psychology, psychiatry, and counseling. This proposal is being made in an attempt to broaden the scope of multicultural competence that these fields claim to embrace and to which they aspire as reflected in their training and licensing practices and published literature. It is hoped that by defining this new minority, that those in the helping professions, and those in professional psychology in particular, might acquire sufficient knowledge with regard to them, their experiences and beliefs, to lessen or counteract the prejudice felt by many of this minority at the hands of larger factions of the consensus reality, including those who uphold the normative psychological perspective and the current dominant materialist scientific paradigm.

To support this proposal, an attempt has been made to provide introductory information regarding six different domains that together comprise the realm of the anomalous and paranormal. An attempt has also been made to situate such non-normative kinds of experience, belief, and behavior on a spectrum or Bell curve that ranges from psychotic dysfunction, on one end, to gifted high functioning, revelatory insight and transcendent experience, on the other end. Finally, 1 suggested approaches for working with those fitting this new category of diversity.

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