

The Psychological Health of Shamans: A Reevaluation*

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INTRODUCTION

THE PSYCHOLOGICAL HEALTH of spiritual practitioners has long been a point of contention, both in the culture at large and among researchers such as anthropologists, religious scholars, and especially mental health professionals. William James wrestled with this issue in *The Varieties of Religious Experience*, and almost a century later the debate continues (Lukoff, Lu, and Turner; Walsh 1980; Wilber 1993). Witness, for example, the title of a report on mysticism by the Group for the Advancement of Psychiatry: *Mysticism: Spiritual Quest or Psychic Disorder?*

Perhaps the most controversial figures of all have been shamans. The range of descriptions and diagnoses that have been given these individuals is nothing less than extraordinary, and two extreme views are now prevalent.

Among mainstream academics probably the most common assessment of shamans is that they are psychologically disturbed individuals who have managed to adapt their psychopathology to social needs. Shamans have been diagnosed, labelled, and dismissed in many ways. To start with some of the kinder diagnoses, shamans have been described as tricksters and healed madmen (Eliade; Warner). The terms neurotic, epileptic, and charlatan have been applied liberally, and the shaman has

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also been called a "veritable idiot," "mentally deranged," and "an outright psychotic" (Devereaux; Wissler). But perhaps the most common diagnoses have been hysteria and schizophrenia (Kakar; Noll).

On the other hand, an equally extreme but opposite view is now appearing in the popular literature. Here shamanic practitioners and their states of consciousness are being beatified and compared with the saints of *Buddhism, yoga, or Christian mysticism*. Consider, for example, the claims that "shamans, yogis and Buddhists alike are accessing the same state of consciousness" (Doore:223) and that the shaman "experiences existential unity—the *samadhi* of the Hindus or what Western spiritualists and mystics call enlightenment, illumination, *unio mystica*" (Kalweit:236). As if this were not enough, shamans have also been described as "psi masters . . . veritable early warning systems for their peoples" (Wescott:340) and, apparently quite seriously, as "a master of death; he actually dies and is actually reborn" (Kalweit:15).

Clearly, then, there is enormous confusion about the psychological status of shamans. Unfortunately both the diagnoses and beatifications of shamans seem to be based on imprecise assessments. With the exception of Noll, there have been almost no careful comparisons of the signs and symptoms of alleged shamanic psychopathology using the criteria outlined in diagnostic manuals such as those of the American Psychiatric Association. Likewise, claims that shamanic states of consciousness are identical to those of practitioners from other traditions have been notably devoid of the careful phenomenological mapping and comparisons necessary for the precise determination of equivalence. When such phenomenological analyses are performed, then significant differences between shamanic, Buddhist, and yogic states, rather than equivalence, leap into view (Walsh 1990, 1993; Walsh and Vaughan). This is not to deny that there may be some overlap in the psychological processes and goals, e.g., attentional training and compassionate service (Peters 1989), of these different practices and states, but it is to say that the states appear to be experientially distinct.

In this paper I want to examine the evidence for claims that shamans are necessarily psychologically disturbed. To do this I will outline the definition of shamanism being used here, describe the shamanic behaviors that researchers have viewed as pathological, summarize some of the biasing factors that historically may have skewed assessments of shamanic health, and then examine the evidence for more common diagnoses, namely, epilepsy, hysteria, and schizophrenia. Finally I will suggest a possible reinterpretation of shamanic symptoms that may encompass and explain both shamanic symptoms and strengths.

DEFINITION

There is no universal agreement on the definition of shamanism (Hultkrantz), and so it is important to make clear the one being used here. There seems to be a spectrum of tribal practitioners, healers, and religious figures who bear a family resemblance to one another (Winkelman 1984, 1989) so that there is probably a certain arbitrariness to any single definition. However, this paper will focus on those individuals who fit the definition of shamanism as a family of traditions whose practitioners focus on voluntarily entering altered states of consciousness in which they experience themselves, or their spirit(s), traveling to other realms at will and interacting with other entities in order to serve their community (Walsh 1989a, 1990).

While no single definition can probably satisfy all researchers, this one has the advantage of being relatively narrow and pointing to a group of practitioners who almost all researchers would agree are indeed shamans. This definition specifically excludes mediums who do not engage in shamanic journeys (soul flight), since although some researchers do include such mediums (Blackler; Peters 1989; Peters and Price-Williams 1983), and although there is clearly an overlap (some mediums may journey and some shamans may act as mediums), mediums and shamans have been reported to show differences in states of consciousness as well as in geographic and social distribution (Bourguignon; Winkelman 1989). In addition, the shamanic journey has been one of the behaviors that has aroused suspicions of psychopathology so that we will want to focus on it in this paper.

This definition seems to clearly distinguish this tradition from other traditions and practices as well from various psychopathologies with which it has been confused. For example, priests may conduct ceremonies and medicine men may heal, but they usually do not enter altered states of consciousness (Winkelman 1989). Mediums usually enter altered states (Bourguignon) but may not journey; some Taoists, Muslims, and Tibetan Buddhists may journey occasionally, but this is not a major focus of their practice (Baldrian; Evans-Wentz; Siegel and Hirschman), while those who suffer mental illness may enter altered states and meet "spirits," but they do so involuntarily as helpless victims rather than as voluntarily creators of their experience.

Of course, we must acknowledge at the beginning that even with a relatively narrow definition such as this, there is no reason to assume that shamans are an homogenous group with identical personalities and pathologies. In fact, psychological testing suggests they are not (Fabrega

and Silver). For all we know, they may no more display a single personality or neatly fit a single diagnosis than do all Western doctors. This may seem an obvious point, but it is amazing how often it is forgotten.

BEHAVIORS THAT MAY INDICATE PSYCHOPATHOLOGY

Three shamanic behaviors need to be assessed, since they have most often been interpreted as pathological. These are the initiation crisis, mediumship, and shamanic journey. The initiation crisis is the dramatic onset of painful symptoms and unusual experiences that marks the beginning of the shamanic life for some practitioners and corresponds to what Joseph Campbell described as "the call to adventure." While mediumship is not universal among shamans, it is common enough and its psychological nature curious enough to have aroused claims by some researchers that it is evidence of psychopathology.

During a journey the shaman enters an altered state of consciousness, then experiences himself or herself as leaving the body and journeying to other worlds (Eliade; Walsh 1989b). The journey contains several experiences that have aroused the suspicion of Western researchers. The first is the altered state of consciousness that the shaman induces, and the second is the rich imagery and visions that accompany it, especially visions of "spirits." Finally, there is the fact that shamans believe that these images, visions, spirits, and worlds are as real as or, in some cases such as the Jivaro Indians, even more real than our ordinary waking reality (Harner 1984).

BIASING FACTORS IN ASSESSMENTS OF SHAMANIC PSYCHOPATHOLOGY

Several factors appear to have biased interpretations of shamans' psychological status. Since these have been reviewed elsewhere (Noll; Walsh 1990), they need only be summarized here.

The first is the general Western "Zeitgeist, the spirit of the times, wherein the Western rationalistic-positive ideology was considered the norm against which other cultures and institutions were judged" (Kakar: 90). A lack of psychiatric expertise and of personal experience of shamanic practices may also have reduced researcher's sensitivity. Likewise, the failure "to distinguish clinic and culture" (Opler: 1092) and reliance on psychoanalytic interpretations can be pathologizing of cross-cultural religious behaviors (Noll). Psychoanalysis has proved particularly problematic in this regard as compared to many other psychological schools because of its marked tendency to interpret unusual experiences—

especially transpersonal and mystical experiences—as pathological. This is an example of “the pre/trans fallacy” in which transpersonal progressions are misidentified as prepersonal regressions (Wilber 1993, 1995).

The fact that altered states of consciousness are involved raises additional concerns. First, there can exist a negative bias towards alternate states of consciousness, a bias that Michael Harner (1990) calls “cognicentrism.” Second, a growing body of research suggests the existence of state-specific limits for understanding alternate states of which one has no personal experience (Noll; Tart 1983, 1992; Walsh 1989c; Walsh and Vaughan). All of the above factors may have biased interpretations of shamanic psychological status.

Of course, bias-free observation is probably a myth, as Francis Bacon long ago pointed out in his discussion of the various “idols” to which we are all susceptible. There are probably no value-free observations, only (relatively) value-aware observers, and we can but try to be aware of these idols as we examine the more common diagnoses attributed to shamans. These diagnoses have been, to use the old and imprecise language found in most of the literature, epilepsy, hysteria, and schizophrenia. Let us therefore examine the evidence for and against each of these venerable diagnoses and then consider more recent interpretations.

EPILEPSY

The conclusion that shamans are epileptics is due to descriptions of their “fits” during initial crises. These fits have rarely been observed directly by anthropologists. Rather information usually comes from shamans’ recollections many years afterwards. This alone would make precise diagnosis difficult, since recollections of past illness can be notoriously inaccurate. The situation is exacerbated because many anthropologists have not known the correct questions to ask in order to allow accurate diagnosis. The net result is a collection of descriptions so vague and so unhelpful that it is quite impossible to determine precisely whether the condition was, in fact, epilepsy, let alone what type of epilepsy might be involved.

Shirokogoroff (347) did observe a series of fits in a woman who desired to become a shaman but was rejected by her tribe. He concluded that:

the most typical picture of hysterical character, with strong sexual excitement, was beyond any doubt: she was lying on a stove-bed in a condition varying between great rigidity (“arch”) and relaxation; she was hiding herself from the light . . . there was temporary loss of sensitiveness to a needle . . . at times continuous movements with the legs and basin

were indicative of a strong sexual excitement . . . Her cognition of reality was rather doubtful, for during her fit she did not recognize persons being around her. However, from time to time, or at least at the end of her fits, she was quite conscious of her surroundings and before a fit she looked for isolation and for certain comfort for herself during the fit.

This description is one of the most detailed in the literature and one of the very few firsthand observations, yet is still not detailed enough to allow certain diagnosis. The description is consistent with "hysterical epilepsy," but definitive diagnosis would require a more precise description of the attack, an account of the patient's experience, and ultimately laboratory data (Sutherland, Tait, and Eadie).

What then are the possible causes of shamanic "fits"? Possible diagnoses would include various types of epilepsy, "hysterical seizures," and emotional agitation. The possible types of epilepsy to be considered would include especially generalized and temporal lobe epilepsies.

Generalized, or grand mal epilepsy, is the classic form of convulsion and in ancient times was known as "the falling illness" and "the sacred disease." After a possible prodromal period of irritability and tension, without warning the patient suddenly loses consciousness, becomes rigid in extension, falls to the ground, ceases breathing, and may urinate. A few seconds of intense whole body tonic spasm is followed by intense jerking movements. The movements gradually become less frequent and finally cease, leaving the patient comatose and flaccid. Consciousness then gradually returns, though the patient often remains confused and drowsy and has no memory of the attack.

Such a clinical picture is, of course, inconsistent with both the "fit" described above and the self reports by shamans who would not be expected to remember such an episode. Consider, for example, the case of a Nepalese shaman who recalled that, at age thirteen, "I began to shake violently and was unable to sit still even for a minute, even when I was not trembling" (Peters 1987: 164).

Of greater possible significance to shamanic pathology is temporal lobe epilepsy. This form of epilepsy is particularly intriguing because it elicits not only changes in behavior but dramatic and unusual experiences. These may include hallucinations, intense emotions ranging from terror to ecstasy, and feelings of unreality (depersonalization or derealization). During this time the patient may display automatisms, which are unconscious stereotypic movements that are quite out of place (Sutherland, Tait, and Eadie)

The unusual experiences that accompany temporal lobe epilepsy might perhaps be consistent with some experiences of initiation crises. However, both the generalized and temporal lobe syndromes are forms of

organic epilepsy and usually reflect chronic neuropathology. Given this fact, it is not surprising that these forms of epilepsy tend to recur over long periods of time. However, the accounts of shamanic "fits" usually imply that the attacks occurred only during the initial shamanic crises and then disappeared spontaneously. This, plus the fact that they occurred only during a time of psychological agitation, suggest that the fits were not organic in origin and hence were neither generalized epilepsy nor temporal lobe epilepsy.

This leaves two other major possibilities: "hysterical epilepsy" or emotional agitation. "Hysterical epilepsy" is a form of what now is described technically as a "conversion disorder" (American Psychiatric Association). Here psychological conflict is expressed as, or converted to, behavior that mimics an epileptic attack. It seems quite possible that some shamanic fits are of this nature. The fact that the fits occur during a time of psychological stress, apparently disappear immediately afterwards, and are expected of would-be-shamans, all suggest the possibility of a psychological cause. Another possibility is that some of the "fits" are simply episodes of intense agitation rather than any true or even hysterical epilepsy.

In summary, available descriptions of shamanic fits are usually so vague, so clinically imprecise, and based on recollections of events so far in the past that it is impossible to make any definitive statement about the incidence of epilepsy in shamans. However, there seems to be little evidence for organic epilepsy, and most fits that do occur may well be examples of either conversion type epilepsy or episodes of agitation. Moreover, only some shamans experience fits, and epilepsy could hardly account for other shamanic experiences such as the shamanic journey. Consequently it is clearly incorrect to label all shamans as epileptics or to imagine that shamanism can be either explained or dismissed on the basis of epilepsy.

HYSTERIA

The second condition that has often been used to diagnose (and sometimes dismiss) shamanism is hysteria. Hysteria is actually an old term for a variety of disorders that are now called conversion disorders and dissociative disorders (American Psychiatric Association). Conversion disorders are thought to occur when a person unconsciously converts psychological conflicts into physical symptoms, as for example with the previously discussed epileptiform episodes.

In dissociative disorders, symptoms are psychological rather than physical. The key element is loss of conscious awareness and control of

certain mental processes such as memory, perception, or identity (Hilgard). Dissociative disorders include multiple personality disorder, depersonalization, and trance states.

We have already discussed conversion disorders and their possible relationship to shamanic fits. We can now consider dissociative disorders and see to what extent they may account for other shamanic experiences. Three types of shamanic experience have been labeled "hysterical," and we can examine each in turn. These three are the initial crisis, mediumship, and the shamanic journey.

With its wide range of bizarre experiences and behaviors it is not surprising that the shamanic initiation crisis has been labeled hysterical. The constellation of dramatic changes in consciousness, identity, and behavior that can accompany it might perhaps be classifiable as an unusual or culturally specific form of dissociation. However, again the major problem is that the descriptions we have of initiation crises are too imprecise, too far in the past, and too lacking in adequate background psychological assessment of the victims to allow accurate diagnosis. Consequently, all we can say at this time is that dissociation might perhaps play a role in initiation crises, but it should be noted that initiation crises occur in only a minority of shamans.

The second aspect of shamanism that might reflect dissociation is the process of mediumship or spirit possession. This process is relatively common, and one survey found it in eleven of twenty-one cultures where practitioners met the criteria for shamanism being used in this paper (Peters and Price-Williams 1980). During this process one or more spirits seem to speak through the shaman whose state of consciousness may vary from full alertness to a complete absence of personal awareness. During this absence the spirit(s) may seem to displace the shaman's personality whose body posture, behavior, mannerisms, and voice may change dramatically.

This type of phenomenon has been surprisingly common across diverse cultures and times and has recently surged again under the name of channeling (Hastings; Klimo; Schultz). Western psychiatry tends to regard this general phenomenon, whatever its name, as a form of dissociation. Witness the *Comprehensive Textbook of Psychiatry* which notes that "a curious and not fully explored or understood form of dissociation is that of the trance states of spirit mediums who preside over spiritual seances" (Nemiah: 150).

There is an interesting clash of worldviews here. For Western psychology and psychiatry, mediumship is a form of dissociation in which the "spirits" are assumed to be splintered fragments of the psyche. For the shaman, on the other hand (and the Western medium or channeler), the

"spirits" are experienced as, and usually believed to be, distinct entities possessing knowledge and wisdom separate from, and often greater than, that of the medium. To decide between these two views may at first glance seem a simple matter. However, analysis soon reveals significant epistemological difficulties in providing definitive proof for either view, leaving us in a situation of ontological indeterminism (Walsh 1990).

However, from a Western perspective, spirit possession would usually be interpreted as an example of dissociation. This does not mean that all shamans can be diagnosed or denigrated as hysterics, since possession occurs in only some of them, is only one of their many role activities, and serves a socially valued function.

A third phenomenon that might be considered dissociative is the shamanic journey. During the journey the shaman enters a trance, becomes less aware of the environment, and experiences journeying to other worlds to contact a rich range of spirit beings and visionary experiences (Eliade; Noll; Peters and Price-Williams 1980; Walsh 1989b, 1990). For a definition and phenomenological mapping of the shamanic trance see Walsh (1990, 1993).

Western psychiatrists might argue that the journey is indeed a form of dissociation, since it involves entering a trance and trances are often described as one form of dissociation. A common implication is that these trances are therefore necessarily pathological. Shamans and their tribespeople would disagree with this. Indeed for the tribe the shamanic journey is regarded as a ray of hope by which healing and help can reach the world from the sacred realms.

There seem to be several arguments against concluding that the shamanic trance and journey are necessarily pathological. The first of these is that the journey is not only culturally sanctioned but culturally valued and that to label it as a disorder may be to "fail to distinguish clinic and culture" (Opler: 1092). Moreover, shamans have control over their trances. They enter trance at will and leave it at will (Peters and Price-Williams, 1983; Walsh 1989b). This is quite different from the classic dissociative disorders which appear to overtake and control their victims. Thus it has been pointed out that:

the Siberian shaman may fall into a state of partial hysterical dissociation like the hysteric in, say Britain, but this state he voluntarily seeks and in doing so he obtains authority and respect from the tribe. (Yap)

Another consideration is that the shamanic journey does not seem necessarily to function as a psychological defense mechanism. In clinical dissociative disorders the dissociation functions, like other defense mechanisms, by unconsciously reducing and distorting awareness in order to

avoid the recognition of psychological pain and conflict. The shamanic journey seems to do almost the opposite. Here shamans deliberately open themselves to either their own pain and suffering, that of their people, or even to that of the "spirits" in other worlds, and thereby attempt to find a resolution to that pain. This is consistent with recent suggestions that dissociation may sometimes be a psychologically beneficial rather than a necessarily only pathological condition (Richards). It may be important to draw a distinction here between dissociation as a psychodynamic mechanism and as a pathology.

Of course, this is not to deny that the journey, or almost any other shamanic behavior for that matter, can sometimes be used as a psychological defense. However, this is very different from saying that the journey serves primarily or exclusively as a defense. Therefore, the shamanic trance and journey may well be culture-specific examples of dissociative mechanisms. However, whether they should be regarded as pathological and examples of dissociative disorders is another question. An appropriate analogy might be a self-hypnotic trance voluntarily induced for therapeutic purposes.

In summary, then, the existence, extent, and nature in shamans of what the literature traditionally labelled as "hysteria" is unclear. Conversion and dissociation may conceivably account for some "fits" and other abnormal behaviors during the shamanic initiation period. However, it is difficult to be sure, since our information about what shamans really experience during this period is imprecise at best.

Dissociation might also be involved in two other shamanic behaviors, namely, spirit possession and the shamanic journey. However, this does not mean that these phenomena should be regarded as nothing but dissociative disorders. To do so risks imposing Western cultural and diagnostic perspectives, thereby reducing and pathologizing these rich, complex, culturally valued, and as yet little understood phenomena to mere diagnostic categories.

SCHIZOPHRENIA

Although shamans' experiences may make perfect sense to them and their tribespeople, they may seem bizarre and incomprehensible to someone from another culture. Consequently it is not surprising that some Westerners have therefore decided that shamans are psychotic and schizophrenic. Thus, for example, one researcher described the Mohave shaman as "an outright psychotic" (Devereaux), and a psychiatrist concluded that schizophrenia and shamanism have in common "grossly non-reality-oriented ideation, abnormal perceptual experience, profound

emotional upheavals, and bizarre mannerisms" (Silverman: 22-23). The only difference that this psychiatrist could see between shamanic and Western schizophrenic episodes was the degree to which the two cultures accepted them.

The bizarre (to the Western mind) shamanic experiences that have most concerned observers and led to diagnoses of schizophrenia have been the initial crisis and the visionary experiences during the shamanic journey. Consequently we need to examine both of these phenomena.

Unlike the initial crisis, the shamanic journey experiences and states of consciousness can be assessed with some degree of accuracy since we possess many detailed accounts of them. These accounts include personal descriptions by shamans, observers' reports, and more recently accounts by Westerners who have undertaken shamanic training. When these descriptions of shamanic journey experiences are subjected to careful phenomenological mapping they are found to display significant differences on several dimensions from schizophrenic experiences (Noll; Walsh 1990, 1993). Consequently it is no longer appropriate to suggest that shamanic journey experiences are evidence of schizophrenia.

For the initial crises, the situation is less clear. As previously discussed, we have very little firsthand data on these crises, and what we have is sketchy. It will therefore be impossible to reach any definitive diagnosis. However, two questions need to be addressed. These are whether the behavior during the crises is consistent with psychosis and, if it is, whether it is consistent with schizophrenia. Let us then first examine the evidence for a possible initiation crisis psychosis.

The diagnosis of psychosis during the initial crisis has been based on both shamans' experience and behavior. At this time shamans-to-be may experience themselves as tormented and controlled by spirits. They may exhibit considerable confusion, emotional turmoil, withdrawal from society, and a range of unusual and even bizarre behavior such as going naked, refusing food, and biting themselves (Boas; Eliade; Peters 1987, Shirokogoroff). These beliefs and behaviors are certainly bizarre by Western standards.

Of course, the belief in spirit possession and persecution is not considered delusional in the shamanic culture. What is unique about shamans is not that they complain of persecution by spirits; it is that they eventually learn how to master and use them (Eliade; Shirokogoroff).

Given the cultural setting and the limited data, we cannot say definitively whether shamanic initiation crises sometimes include psychotic episodes. All that we can conclude is that the bizarre behavior, emotional turmoil, confusion, and incoherence could be consistent with a psychotic episode. Therefore it is possible that some would-be-shamans who are

compelled to their profession by an initial crisis may undergo a temporary psychosis.

If a psychotic episode does occur during the initiation crisis, then there seem to be four possible diagnoses that might be given to it. The first is a brief reactive psychosis. As the name suggests, this is a brief stress-induced episode lasting from a day to a month, often marked by considerable emotional turmoil, yet with eventual full recovery (American Psychiatric Association).

Other possible diagnoses would be schizophrenia or its short-lived variant, schizophreniform disorder. Current diagnostic practices require continuous signs of psychopathology for at least six months before a diagnosis of schizophrenia can be made. Where disturbances are shorter but the clinical picture is still consistent with schizophrenia, then the diagnosis of schizophreniform disorder is made (American Psychiatric Association).

The fourth possibility would be "psychotic disorder not otherwise specified." This diagnosis is given when a psychotic episode does not meet the diagnostic criteria for specific psychotic disorders such as schizophrenia or when there is inadequate information to make a specific diagnosis.

If a psychotic episode does indeed occur during initiation crises, then its differential diagnosis includes these four categories. What is the evidence for and against each of them? Given how limited and unreliable the clinical data is, it will obviously be impossible to make a definitive diagnosis, although we can consider the possibilities as follows. The American Psychiatric Association's *Diagnostic and Statistical Manual* suggests that the diagnosis of psychotic disorder not otherwise specified should be used for psychosis about which there is inadequate information to make a specific diagnosis. This certainly fits the shamanic situation, and so we could simply say that if a psychotic episode does occur during the initiation crisis, then it can be considered of this type.

However, it is schizophrenia that has been the most common diagnosis. This may partly reflect a lack of psychiatric/psychological sophistication among early anthropological researchers. Nonmental health professionals are often unaware of the many varieties of psychosis and therefore assume that all psychoses are schizophrenic. Indeed, although schizophrenia has been the most common diagnosis, it seems the least likely because of the brief duration of the initial illness and its successful outcome.

There are also other data that argue against either a schizophrenic or schizophreniform diagnosis. The first of these is that many shamans have seemed not at all schizophrenic to anthropologists. Likewise, native peoples often make sharp distinctions between shamanic crises and mental

illness. Moreover, shamans often seem to end up not only psychologically healthy but even exceptionally so. This is in marked contrast to schizophrenics of whom about a third deteriorate progressively over the years (Kaplan and Sadock). Indeed this exceptional psychological well-being of shamans also argues against most of the other diagnoses that have been made, e.g., epilepsy and hysteria. While some patients may recover spontaneously from any of these, one would not usually expect them to end up as the most able members of society.

Moreover, shamans end up serving the community. Indeed, this is one of their defining characteristics, while schizophrenics rarely make major contributions. Several researchers have pointed to a correlation between psychological health and service, for example Alfred Adler's "social interest," Eric Erikson's "generativity," Abraham Maslow's self-actualizer's generosity, Pitirim Sorokin's "creative altruism," and, of course, the "selfless service" described in several Asian psychologies (Walsh 1988; Walsh and Shapiro; Waterman). Since healthy people tend to devote themselves more to aiding others, this may be a further argument against seeing the shaman as psychologically disturbed.

It would be helpful in assessing the health of shamans to have good psychological test data. Unfortunately there is very little available at the present time. A Rorschach study of Apache Indians that has been widely cited found no evidence that shamans are severely neurotic or psychotic (Boyer, Klopfer, Brawer and Kawai). Unfortunately this study was flawed in several ways, and so the evidence it provides is very weak (Fabrega and Silver). Another study revealed a striking similarity between the unusual Rorschach test patterns generated by an Apache shaman (Klopfer and Boyer) and a Buddhist meditation master (Brown and Engler), but it is impossible to generalize from a single case. At the present time psychological tests are therefore of little help in evaluating the shaman's personality or psychological health.

What then can we conclude about the oft repeated claims echoing through decades of literature that shamans are healed madmen at best or actively psychotic and schizophrenic at worst? The experiences most often diagnosed as psychotic have been shamanic journeys and initial crises. Of the shamanic journey we can clearly say that it is a unique experience that should in no way be confused with psychosis.

The initial crisis is less clear, and some of those shamans who undergo such a crisis might suffer a temporary psychotic episode. However, it is important to note that only a small percentage of shamans undergo initial crises, and, of these, probably only some experience psychosis. This means that only a very small percentage of all shamans would suffer a psychosis. Moreover this psychosis is usually short-lived

and for a variety of reasons seems most unlikely to be a form of schizophrenia. In addition, the shaman may end up as one of the healthiest members of the tribe.

This is not to say that all shamans are models of health and helpfulness. Indeed, some engage in all manner of trickery and deceit, their intentions can be malevolent (Harner 1984; Rogers; Warner), and their ministrations sometimes merely delay adequate treatment (Li and Phillips). However, it is now clear that contrary to decades of speculation, the majority of shamans cannot be diagnosed as mentally ill or labeled as epileptic, hysterical, schizophrenic, or psychotic.

REEVALUATING THE INITIATION CRISIS

Perhaps what is just as important as the initiation crisis itself is what comes out of it. According to Eliade the shaman is a person "who has been cured, who has succeeded in curing himself" (27). From this perspective "shamanism is not a disease but being healed from disease" (Ackerknecht: 46).

In fact, shamans may end up as the most highly functional members of the community and, according to Eliade (29), "show proof of a more than normal nervous constitution." They have been described as displaying remarkable energy and stamina, unusual levels of concentration, control of altered states of consciousness, high intelligence, leadership skills, and a grasp of complex data, myths, and rituals. So the symptoms and behavior of shamanic initiation crises are unusual and even bizarre by both Western and tribal standards. Yet shamans not only recover but may function exceptionally well as leaders and healers of their people (Eliade; Reichel-Dolmataoff; Rogers).

What then can we make of this curious combination of initial disturbance and subsequent exceptional health? With the exception of existential crises (Bugental; Yalom), the possibility of exceptional health following psychological disturbances, especially psychosis, is rarely recognized by mainstream psychiatry and psychology. We are left, therefore, to ask whether there are any data and diagnoses that could encompass *both* the initial pathology and the subsequent recovery? Is there an alternative framework for understanding shamanic crises?

The answer is clearly yes. Shamans are certainly not the only people observed to be better off after a psychological disturbance than before it. Over 2000 years ago Socrates declared that "our greatest blessings come to us by way of madness, provided the madness is given us by divine gift" (Lukoff: 155). More recently the eminent psychiatrist Menninger observed that "some patients have a mental illness and then they get

weller! I mean they get better than they ever were. . . . This is an extraordinary and little realized truth" (Lukoff: 157).

In our own time a surprisingly large number of mental health professionals have made similar observations. I say surprising because the possibility is barely mentioned in traditional psychiatric texts. Yet a significant number of researchers, some quite eminent, have recognized that some psychological disturbances, even including psychoses, may function as growth experiences that result in greater psychological well-being. Examining these disturbances may therefore shed light on shamanic initiation crises.

The general process is one of temporary psychological disturbance followed by resolution and repair to a higher level of functioning than before the initial crisis began. From this perspective what seemed at the time to be purely a crisis of disturbance and disease can now be reinterpreted as a stage of development and growth. These crises have been given many names, and each of them illustrates a different perspective and piece of information about the process. For example, disturbances with positive growth outcomes have been described as "positive disintegration," "regenerative processes," "renewal," "resilience," and "creative illness" (Dabrowski; Ellenberger; Flach; Peller and Garfield; Perry).

Some crises are either induced by contemplative practices or are specifically associated with mystical or transpersonal experiences. These have been described as "visionary states," "divine illnesses," "spiritual emergencies," "spiritual emergences," "mystical experiences with psychotic features," and "transpersonal crises" (Grof and Grof 1986, 1989, 1990; Laing; Lukoff 1985; Vaughan 1995a, 1995b).

What these names and descriptions suggest is that a period of psychological disturbance may sometimes be part of, or at least be followed by, significant growth and development. Thus there is the possibility of viewing these disturbances as developmental rather than merely pathological processes. Consequently some, but only some, psychological disturbances can now be seen as developmental crises.

These crises can be precipitated by stress or spurred by psychological or contemplative practices. They can also occur spontaneously and express inner developmental forces that have been described by such terms as pulls towards individuation, self-actualization, self-transcendence, and eros (Maslow; Singer; Wilber 1980, 1995). These developmental forces can become quite compelling, and, then, as the Jungian psychiatrist John Perry observed, "if development is not undertaken voluntarily with knowledge of the goal and with considerable effort, then the psyche is apt to take over and overwhelm the conscious personality. . . . The individuating psyche abhors stasis as nature abhors a vacuum" (Perry: 35)

In other words, the psyche may actually create crises that force development. Such can certainly be the case with shamans. Many are not the least bit pleased by the prospect of their new profession and resist the initial signs and symptoms with all their might, what Joseph Campbell calls "refusal of the call." However, resistance is no easy matter, and many tribal myths hold that the person who resists the call will sicken, go mad, or die (Boas; Eliade).

When the forces of growth overwhelm the forces of inertia, then a developmental crisis occurs. The symptoms of this crisis may vary depending upon the individual's personality and maturity. They may range from primitive pathology to existential, transpersonal, or spiritual concerns (Wilber, Engler, and Brown). In the latter case the crisis has come to be known as a transpersonal crisis, spiritual emergency, or spiritual emergence (Assagioli; Grof and Grof 1986, 1989, 1990), and it is these that seem closest to and most helpful in understanding the shamanic initiation crisis.

The study of transpersonal crises or emergencies is in its infancy as yet. Although they have been described for centuries as complications of spiritual practices, careful examination, classification, and systematic treatment have only just begun. Contemporary researchers have described several varieties of transpersonal crises. Of these one type bears such a resemblance to the shamanic crisis that it has specifically been named a crisis "of the shamanic type" (Grof and Grof 1986, 1989, 1990). It is claimed that:

Transpersonal crises of this type bear a deep resemblance to what the anthropologists have described as the shamanic or initiatory illness. . . . In the experiences of individuals whose transpersonal crises have strong shamanic features, there is great emphasis on physical suffering and encounter with death followed by rebirth and elements of ascent or magical flight. They also typically sense a special connection with the elements of nature and experience communication with animals or animal spirits. It is also not unusual to feel an upsurge of extraordinary powers and impulses to heal. . . . Like the initiatory crisis, the transpersonal episodes of a shamanic type, if properly supported, can lead to good adjustment and superior functioning. (Grof and Grof 1986: 10-11)

The similarity of these experiences—death-rebirth, magical flight, animal spirits, impulses to heal—to classic shamanic experiences is striking. Thus, it seems that shamanic initiatory crises may reflect psychological processes not limited to a few cultures or times. Clearly some deep, perhaps archetypal, pattern is being played out here. Such was certainly the view of Jung who argued for "the psychological inference that may be drawn from shamanistic symbolism, namely that it is a projection

of the individuation process" (Jung: 341). The Grofs therefore conclude that individuals whose crises follow this pattern are "involved in an ancient process that touches the deepest foundations of the psyche" (Grof and Grof 1986: 11) Of course, it is quite possible that future research will reveal that there is more than one specific syndrome or type of shamanic crisis.

Clinical observations suggest that several factors may be helpful in treating transpersonal crises. The first is a trusting relationship in which the patient feels cared for and safe. The second is a specific cognitive set, namely, a positive attitude in which the patient expects that the process will prove valuable and may ultimately be transforming and healing. Such attitudes in patients also favor good therapeutic outcomes in other psychopathologies (Flach). Openly expressing the emerging experiences can be helpful and can be facilitated by a variety of psychotherapy techniques (Grof and Grof 1990).

It can now be seen how the shamanic initiation crisis may fit into this scheme. The crisis contains symptoms and behaviors that appear bizarre and even pathological. Even if the descriptions available to us are not precise enough to be able to diagnose the crises precisely, it is clear that they are often painful—even traumatic—episodes. However, their outcome may be positive when the shaman-to-be is recognized as such by the tribe and receives culturally appropriate support, guidance, and "therapy." This support/therapy includes a relationship with an experienced shaman, a positive reinterpretation (what cognitive therapists would call reattribution) of the disturbance as part of a shamanic call, and shamanic practices that enable the novice to work with the emerging experiences. With this assistance the shaman may not only recover from the initiation crisis but may emerge strengthened and enabled to help others. In short, for centuries shamanic cultures seem to have provided the types of support that contemporary therapists are now finding helpful for spiritual emergencies.

It therefore appears that transpersonal crises, spiritual emergencies, or spiritual emergences, may be newly recognized forms of perennial developmental crises. This developmental perspective allows us to view both shamanic crises and contemporary transpersonal crises as related, difficult, but potentially valuable maturation crises. This perspective also helps us to recognize both the psychological disturbance as well as the potential for growth. As such it denies neither the pain and pathology nor the potential for development.

Since developmental crises tend to bring unresolved conflicts to the surface, it follows that shamanic initiation crises may be a mix of progressive and regressive forces, signs of growth and symptoms of pathology,

and a comprehensive account will recognize both. However, at the very least, it no longer seems appropriate to dismiss shamans and their initiation crises as invariably and purely pathological. Something much richer, more complex, and more beneficial seems to be going on and deserves open-minded research.

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