ABSTRACT: Students and clients often ask: “What is psychological illness?” “How do people get such an illness and how do they get better?” and “What does emotional health look like?” The purpose of this article is to propose a model that offers answers to these questions with a diagram, constructed as a hypothetical continuum of “background emotions” (Damasio, 1994, 1999), overlaid by the normal curve. Transpersonal psychotherapists may find this model useful because of its alignment with some of the basic assumptions that define the transpersonal field and because it offers a broader and more transpersonal perspective in answer to these questions. The model is described, related to transpersonal assumptions, and contrasted with the DSM model. Clients are described whose treatments using the model resulted in transformational changes. Suggestions for future research are offered.

KEYWORDS: transpersonal, emotional health, background emotions, transformational model

There are abundant theories in the psychological field that aspire to answer the questions posed in the abstract; however, the answers the theories generate are surprisingly diverse and do not offer a single, unified, or relatively simple response. The purpose of this article is to propose a model that offers answers to these questions with a diagram that can be used by students, instructors of counseling education, psychotherapists, and clients and that may also be of interest to theorists and researchers. The diagram is hypothetical and does not represent a single person’s experience nor that of any group of people. It is designed to represent what an “average” person’s potential emotional experiences in a lifetime might be.

Transpersonal psychotherapists may find this model particularly useful because of its alignment with several basic assumptions that define the transpersonal field, such as holism and intrinsic health and because it suggests a trajectory for transpersonal growth that develops naturally from a healthy egoic emotional state. It is bilateral and homeostatic and provides a way to conceptualize human emotional experience that is an alternative to the more familiar DSM model. It is also consistent with other current research.

This article contextualizes, constructs, and then describes a transpersonal model of psychological illness and health and the dynamics between them by examining the questions posed in the abstract. The model is then related to fundamental transpersonal assumptions and contrasted with the DSM –5 (APA, 2013) model. Finally, clients are described whose treatments using the model resulted in transformational changes. Some suggestions for future research follow.
What Is Psychological Illness?

Mental Illness Defined

Since the mental hygiene movement of the early 1800’s, the terms *psychological*, *emotional* and *mental* have been used somewhat interchangeably to describe illnesses that are primarily or symptomatically expressed through feeling, emotional or cognitive states as opposed to those expressed through more somatic or physical states. The three terms generally relate to phenomena of the mind or mental states or are functions of awareness, feeling or motivation. It is also generally recognized, however, that (a) there is no real distinction between mental and physical, (b) the mental disorders (more so than the physical ones) lack a consistent operational definition and vary more widely in how they are manifested (APA, 2000, pp. xxx-xxxi).

For purposes of this article, the terms psychological, emotional and mental are used interchangeably and refer essentially to the same general human states identified in the DSM-5 (APA, 2013) and elsewhere to describe human feelings. The DSM uses the term *mental disorders* for illnesses in emotional arenas and provides the following definition, which will satisfy the need for a common understanding of some of the concepts dealt with herein. A mental disorder is defined as:

...a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from dysfunction in the individual, as described above. (p.20)

Historically, the study of mental illnesses borrowed templates from the medical community used to categorize, diagnose, and treat physical illnesses. Now after nearly 60 years of revisions, the DSM-5 (APA, 2013) has become increasingly more sophisticated and comprehensive in identifying, categorizing, and describing the syndromes of mental disorders that are thought to benefit from medical treatment. While the focus on identification and diagnosis of physical illnesses has resulted in consistently improved treatments using medication and/or surgery over the past century, it is arguable whether the diagnostic focus on mental illnesses has produced similar confidence in treatment efficacy for mental disorders.

In addition, the focus on diagnosis in mental arenas has had a subtle but unmistakable effect on the general public’s understanding of and relationship to mental illness. Clients and counseling trainees alike expect to be given a prescription for curing their emotional distress through medication or, at the least, finding the correct identity of whatever it is that feels bad so that it can be “fixed”
by using the correct treatment protocol. Unfortunately, curing emotional illnesses has not been found so far to be as simple or straightforward as we might have hoped, and this focus on diagnosis and medical treatment may now actually be impeding the ability of those with such illnesses to find their way to greater emotional health, particularly without medication. Emotional health may be more readily achieved by expanding the view of human emotional experience from a primarily disease perspective to a more holistic and wellness perspective and encouraging psychotherapeutic interventions that stimulate transformational adaptation responses to emotional pain.

Emotions Defined

There is a lack of agreement in the scientific community about exactly what an emotion is and just how important it is in human functioning. Opinions range from emotions having little or no importance, where cognitive and information processing models subsume emotion (Beck, 1976), to emotions being the “cornerstone of consciousness” (Damasio, 1994, 1999). Other concepts such as temperament and mood are sometimes discussed in relation to, or instead of, emotion. These terms seem to be used to describe inclinations in likelihood or duration of subjective states but seem even less concrete and accepted in psychological circles than the term emotion.

Other researchers (Ekman & Davidson, 1994) suggest emotions are a subset of the broader class of what they call affective phenomena. Emotions are conceived of as multicomponent response tendencies that develop over short time frames. Affect is the more general concept and refers to consciously accessible feelings. These authors use the term emotion when there is a personally meaningful circumstance. Affect is used when the feeling is free floating or objectless, the experience is more long lasting, and when there is a two-dimensional perspective of the sensations in the body: positive or negative.

Recent advances in technology have enabled more biological definitions of emotion to emerge. I will use Siegel and Hartzell’s (2003) biological definition of emotion as a foundation. I will not discuss mood or temperament as concepts but will instead use the concept of background emotions, used by Damasio (1994, 1999) to discriminate between relative feeling states. Damasio identifies what he calls the background emotions, that allow us to have a “felt sense of well being or malaise, calm or tension” (1999, p. 51). Background emotions provide us with an overall sensation of “tension, relaxation, fatigue or energy, anticipation or dread” (1999, p. 52). It is this kind of emotional experiences—the background emotions—that are most likely to be internally experienced as emotional health or illness and that are also the focus of this article.

Emotions that are the most personally difficult, often labeled as “unhealthy,” and generally seen as “negative,” such as depression and anxiety have been studied more than positive ones. The scientific goals related to these “difficult” emotions have largely been to (a) operationally define and accurately assess them through empirical, physiological, or behavioral symptom markers and (b) eliminate them, a
goal that continues to be of significant psychotherapeutic and psychopharmacological interest. Western psychology has defined nearly 300 such unhealthy conditions in the DSM–5, listing a menu of pathologies that the DSM identifies as “mental disorders” (APA, 2013).

All of these efforts define emotions as egoic experiences and support the idea that one must have a relatively healthy emotional status and ego in order to function well. They also support the idea that a healthy-enough ego provides the foundation to grow beyond the ego (Engler, 1993). Transpersonal states and interests may be more readily achieved as energy is freed up by egoic emotional concerns that are resolved.

**Proposing a Transpersonal Model**

**Context for the Proposed Model**

The psychological models most frequently used to describe emotional states, especially the most commonly accepted model, which is the DSM–5 (APA, 2013), do not describe a range of emotional experience that is considered normal, nor do they describe how normal emotions change. Even though a huge number of people today are on medication to achieve the supposed feeling of emotional health, there has been less emphasis on defining emotional health and how it is cultivated than there has been attention to identifying pathology. The concept of prevention has also not yet been explored widely, although the increase in public interest in alternative medicine suggests that this would be of significant help to many.

Several of Freud’s contemporaries recommended a less negative, less restrictive and less deterministic focus in the newly developing field of psychology at the turn of the last century, including William James, Carl Jung, and Roberto Assagioli. Their early work on more positive and transcendent states of mind preceded even the creation and development of psychology’s third force, Humanistic Psychology, launched by Maslow, Rogers, Sutich, Satir and others in the late 1950’s and early 1960’s. Publication of the first edition of *The Journal of Transpersonal Psychology* in 1969 afforded Sutich the opportunity for some retrospective reflections (Sutich, 1969). He reminisced about how Maslow’s leadership toward a more healthful view of being human had inspired him (Sutich, 1961) to define the humanistic “third force” psychology in the first issue of *The Journal of Humanistic Psychology* as “concerned with topics having little place in existing theories and systems: e.g., love, creativity, self, growth...self actualization, higher values,...psychological health” (p.2). Maslow’s (1950) work further brought positive emotion back into the scientific conversation and to lay readers in the 1960’s with his book *Religions, Values, and Peak-Experiences* (1964).

Psychosynthesis, a more inclusive approach to mental health according to Keen (1974), dates from 1911 and the early work of Roberto Assagioli, an Italian psychiatrist. Freud’s focus only on the “basement of the human being” was countered by Assagioli who maintained that Freud had not given sufficient weight to the “higher” aspects of the human personality. Jung also developed several
therapeutic practices such as art therapy and active imagination that led to deep healing integration of the personality, which he called individuation. These researchers, as well as others, are pioneers of the transpersonal psychology movement, which was not formally established and named until the late 1960’s with the publication of The Journal of Transpersonal Psychology.

Recently, a surge of interest in positive psychology (e.g., Seligman & Csikszentmihaly, 2000) was generated through the publication of several self-help books. Positive psychology has a rapidly growing body of research that has as its purpose the elucidation of positive, emotionally healthy states of being. Unfortunately, a focus on “happiness,” without the balance created when the full range of experiences are portrayed, may increase the cultural inclination to trivialize emotional experiences and further sensationalize the current cultural impetus to employ psychotropic medication or an addictive substance as the cure for all ills.

The Humanistic and Transpersonal Psychology fields, the pioneers of these two fields, and the research on positive psychology are the most notable exceptions to the claim that mental health has been less researched in Western psychology than mental illness. The transpersonal field assumes that human beings are inherently healthy and should be evaluated from a holistic perspective. Much of the work done in the transpersonal field revolves around promoting psychological health and defining its qualities but it has not detailed how egoic emotional illness may retard transpersonal growth.

The transpersonal literature contains several important examples of work on mental health. In addition to Maslow’s work cited earlier, Wilber’s (2000) Integral Psychology is another example. Wilber describes and integrates the world’s known developmental theories into a “spectrum of consciousness.” His work details and expands the concepts of development into multiple levels, waves, lines and streams, and provides an organization for all of them known as all quadrant, all level (AQAL). This work attempts to consolidate the known areas of potential human growth, and emotional health would presumably be age-appropriate development along various dimensions. Wilber articulates spiritual development as the growth edge for evolving our current planetary consciousness.

Many authors have expanded on Wilber’s (2000) Integral Psychology model. Ingersoll (2002), for example, recommends an integration of Wilber’s (1995) integral model expanding the DSM diagnostic perspective to include Wilber’s four quadrants and a variety of the developmental levels. He calls his application an “Integral Approach” to diagnosis and demonstrates through a case example how the view of “Katie” through each of the quadrants and “eyes” expands her personhood. Ingersoll recommends diagnosis involving multiple levels of reality, multiple perspectives, and multiple lines of development. Ingersoll emphasizes that the Integral Approach is a wellness orientation, limits labeling based on oversimplified categories, and is less dissonant for counseling students than the disease/pathology models. The DSM, he says, commits a category error by trying “to use the quadrant of the objective self to account for all aspects of the self” (p.122).
Another example of a more bilateral orientation to emotional diagnosis is Hutchins (2002) work, which expands on the DSM IV-TR (2000) 5-axis model to incorporate 5 parallel axes he calls “Gnosis,” which list the person’s gifts and abilities. On Axis I, he identifies the person’s “Callings and Goals” and on Axis II “Core Gifts and Abilities.” Axis III lists “Physical Gifts.” Axis IV’s are “Psychosocial and Environmental Supports,” and on Axis V “System Gifts: Family/ Community/ Culture” are noted (p. 101). Hutchins articulates a consequence of failing to acknowledge a broad view of human emotional functioning:

Labeling someone as schizophrenic or borderline can be a virtual life sentence. It can impose a reality on that person that can be difficult if not impossible to escape. When we as clinicians focus solely on our clients’ problems, there is a serious risk that they will be reduced to clinical descriptions of pathology (p.101).

Buddhist psychology has traditionally presented a bilateral perspective of emotional well being and so is another exception to the claim that wellness models have not been as valued in traditional psychological circles. The Dalai Lama pointed out in his text, *The Universe in a Single Atom* (2005), that the Western view of positive and negative emotions does not parallel the Buddhist perspective of wholesome and afflictive mental processes. Western models generally differentiate “positive” and “negative” emotions on the basis of internal feelings; the Buddhist perspective differentiates them on the “roles these factors play in relation to the acts they give rise to” (p.178). Emotional health and its cultivation are central topics in Buddhist psychology, and the ancient practice of mindful meditation is among the most successful strategies for intervention in mental illness that Western psychologists have found to date. Recently, Daniel Goleman and the Dalai Lama (2003) addressed “destructive emotions and how to overcome them” in their text of the same title, recognizing the need for instruction on cultivating greater wellness.

Other notable exceptions that emphasize states of mental well being in the social sciences include the research on resilience, which has received a great deal of attention since the early work of Rutter (1987). The concept of resilience is now widely accepted to account for some people’s ability to resist or bounce back from adversity. More recently, researchers have developed strategies for resilience training or inoculation that focus on teaching and promoting resilience. For example, a recent article describes a therapeutic approach for veterans transitioning to civilian life (Osran, Smee, Sreenivasan, & Weinberger, 2010). These researchers have been teaching returning vets to develop a transpersonal, resilience-promoting way of “reframing” their combat losses, which has proven to be a valuable tool in veterans’ successful reintegration into civilian life.

The idea that tragedy and suffering trigger personal transformation is an ancient one, as can be seen in the world’s literature and religious traditions. Frankl (1963) and Yalom (1980) are two psychologists who have identified how traumatic and adverse events can foster psychological growth. Tedeschi and Calhoun (1996) developed the Posttraumatic Growth Inventory, which has allowed researchers to assess five domains of growth frequently reported by survivors: renewed
appreciation of life, new possibilities, enhanced personal strength, improved relationships with others, and spiritual change. Tedeschi and McNally (2011) demonstrated that combat veterans benefit from therapy focusing on these five areas.

Another fruitful area of research on emotional strength is being conducted on the construct of “hardiness” (Salvatore, Khoshaba, Harvey, Fazel, & Resurreccion, 2011). It is a “construct with interrelated attitudes of commitment, control, and challenge that together provide the existential courage and motivation to turn stressful circumstances from potential disasters into growth opportunities and is considered the pathway to resilience” (p. 369).

Additionally, both Somatic Experiencing (Levine, 2010) and Hakomi (Kurtz, 1990) therapies are thought to support the development of new neural pathways of growth and health through immersing clients in corrective body-based experiences that stimulate positive or “expansive” experiences and that also generate competing resourceful states to replace old patterns of distress or traumatic responses.

Fredrickson (2000) demonstrated empirically that the positive emotions override physiological changes to the cardiovascular system brought about by negative emotions. Fredrickson, Mancuso, Branigan and Tugade (2000) hypothesized that either replacement or undoing was responsible for this change and found support for the undoing hypothesis. Exactly how this works is still open for discussion.

The model described in this article addresses some basic questions about egoic emotional well being and refocuses attention on the pragmatic, personal need for health-promoting answers to what emotional health is and how to cultivate it. It offers a perspective on a normal range for emotions and a potential definition of emotional health and illness as well as how emotions change. It is simpler than a diagnostic Integral Approach might require, and it is consistent with known research, including Eastern perspectives of emotion. The proposed model, when used in psychoeducational and psychotherapeutic settings, may be found to be another way to increase or promote resilience and increase personal resources. It reframes current conceptual constructs regarding mental and emotional illness and well being.

The Definition of Emotion Underlying the Proposed Model

There seems to be general agreement that scientists, even those studying emotion, have yet to arrive at an agreed-upon definition of emotion (Siegel, 2010). Recent progress in neurophysiology, however, brought about by access to sophisticated laboratory instruments such as brain scans and MRIs, has focused on more physiologically based definitions. One such example is Siegel and Hartzell’s description of primary emotion (2003):

First, the brain responds to an internal or external signal with an initial orientation response that activates the mind to focus attention. This initial orientation basically says, “Pay attention now! This is important!” Next, the
brain responds to that initial orientation with an appraisal of whether that signal is “good” or “bad.” This appraisal is then followed by the activation of more neural circuits, which elaborate, or expand, this activation into associated brain regions. This appraisal/arousal process can be thought of as the fundamental surges of energy in the mind that accompany the processing of information. These elaborated appraisal processes are how the brain creates meaning in the mind. Emotion and a sense of meaning are created by the same neural processes. As we’ll see, these same circuits of the brain also process social communication. Emotion, meaning, and social connection go hand in hand. (pp. 60-61)

Siegel and Hartzell (2003) explain that primary emotions provide the body’s first assessment of the importance and hedonic value of the incoming stimuli, and they organize the body toward action. Emotions occur all the time as we receive the constant influx of stimuli from sensory receptors, proprioceptors (muscular and joint) and interoceptors (visceral), and emotions seem to come and go as the input changes. But according to Siegel and Hartzell, there is an additional component that lends complexity to the concept of emotion. They are of the position that emotion can be thought of as a process that integrates entities into a functional whole” and suggest that it is emotion that brings “self organization to the mind.” They stress that it is emotion that is at the crux of our “sense of well-being in ourselves and in our relationships” (p. 59).

Damasio (1999), a neurologist, agrees that emotion is likely a “cornerstone” of the essence of what we know to be human consciousness. He categorizes the primary emotions into six universal emotions including sadness, happiness, fear, anger, surprise, and disgust and what he calls the secondary social emotions, such as embarrassment, jealousy, guilt, and pride. Other researchers and spiritual leaders have used similar categories to delineate the variety of emotions we experience (i.e., Dalai Lama, 2005), although the Buddhist categories of emotion are substantially more developed than this list suggests. See for example a listing of the healthy factors, including 51 key mental factors, 5 universals, 5 factors of object discernment, 11 wholesome mental factors and an even more complex categorization of the afflictive mental processes in the Dalai Lama’s 2005 text (pp. 176-183).

According to Siegel and Hartzell (2003) and Damasio (1994, 1999), then, emotions involve (a) an internal or external signal or stimulus, (b) the initial orientation response (focus and attention), (c) the appraisal of good or bad (value positive or negative), (d) brain processes that elaborate the subjective meaning of the signal for the organism (comfort, danger), and (e) an organization of the body to action (move toward, move away from).

Emotions are also hypothesized to be (a) connected with meaning and social relationships, (b) part of a process that integrates a sense of “selfness” or “wholeness” to entities such as “self” and “other,” suggesting they are the “cornerstone” of consciousness, (c) determinants of a sense of “well being” or not, and (d) commonly classified by Western psychologists and researchers into categories including primary and secondary, or positive and negative.
Background Emotions

Closely related to the primary and secondary emotions, Damasio (1994, 1999) describes, as noted earlier, a category of emotion that he calls the background emotions; these allow us to have a “felt sense of well being or malaise, calm or tension” (1999, p. 51). Damasio suggests that what induces the background emotions is usually internal (from inside our bodies), and he notes that it is these physical sensations that are physiologically “attached to drives and motivations and to the states of pain and pleasure” (1999, p. 51). Background emotions provide us with an overall sensation of “tension, relaxation, fatigue or energy, anticipation or dread” (1999, p. 52).

It is this arena of emotional experiences—the background emotions—that are most likely to be internally experienced as emotional health or illness and that are also the focus of this article. Most people do not worry too much about having feelings such as anger or fear or any of the other primary and secondary emotions, though they might not like them or feel they have time for them, but it is usually a more pervasive sense, or background feeling, of an ongoing and general feeling of disease that makes people feel they are no longer emotionally healthy. In this way, the emotional sense of well being mimics that of physical well being. While most of us would not run to the doctor if we felt an occasional strong pain (primary or secondary emotion), we often consider our need for a doctor if the pain is chronic and interferes with our ability to carry on with everyday life (background emotion).

Damasio (1994) does not directly distinguish the background emotions from “temperament” but acknowledges, “the collection of background feelings (over time) probably contributes to a mood” (p. 151). However, the background emotions are not quite the dispositional type of experience known as “mood” or “temperament,” nor are they the emotions themselves. He surmises that:

A background feeling is not what we feel when we jump out of our skin for sheer joy, or when we are despondent over lost love; both of these actions correspond to emotional body states. A background feeling corresponds instead to the body state prevailing between emotions. The background feeling is our image of the body landscape when it is not shaken by emotion. I submit that without them the very core of your representation of self would be broken. (pp. 150-151)

The hypothetical model described in this article uses the combined definitions of emotion constructed by Siegel and Hartzell (2003) and Damasio (1994, 1999), and specifically Damasio’s (1994, 1999) explanations of background emotions as fundamental precepts. The model also patterns itself on a physical health and illness model where emotional well being and illness are experiences that are internal to the body and reflect a subjective, overall sense of an emotional feeling state, enduring between primary and secondary emotions in response to ongoing stimuli. While it is not yet clear how all the terms are related, including character traits, mood, and temperament, it is this overall sense of emotional well being and decline that the continuum of background feeling states attempts to capture.
A Hypothetical Continuum and Normal Curve for Feeling States

It is important to realize that these are not constructs that have yet enjoyed wide scientific support or empirical verification. From the term emotion, to background emotions, to the continuum and the labels assigned here in this article, the constructs are not operationally defined nor have they been subjected to extensive empirical study, particularly as the terms are being used here. Nevertheless, a hypothetical model can be constructed that has our collective, internal experiences to validate it at this time. Experience and internal investigation are the first line of recognizing that which may inform scientific clarity in the future. In the absence of empirically verified data on background emotions, I recommend constructing a model of emotional experience by using the familiar diagram of a continuum to represent the range of emotion most humans, presumably, have the capacity to experience in their lifetimes.

Constructing the continuum requires generating a series of labels that can be used to represent the variety of background emotional experiences most people encounter in their lives. So, let the model begin with a horizontal line for the continuum and some markers describing background states from generally painful to generally pleasurable. The continuum can also suggest more and less painful, and more and less pleasurable states, by adding number markers in between the poles. Labels can be added in between the number markers to describe a particular quality of feeling on the continuum.

The normal, or bell, curve is then overlaid on the continuum to show the hypothetical, relative frequency of each feeling state. The bell curve has been used to describe various human characteristics, from shoe size to intelligence, and has been mathematically and statistically verified. It is frequently used to characterize human qualities that have not been scientifically or practically quantified. Currently there is no strategy for assessing or for measuring the range of background emotions, let alone for whether these are consistent among human beings. However, the continuum described here is intended to stand for a hypothetical range of probable background emotions based on internal observations of our own and others’ self-reported emotional experiences. In turn, this range would theoretically be governed by the bell curve theory, which would allow the relative frequency of each general type of background feeling to be predicted.

Proposing a Transpersonal Model

For purposes of this model, the two poles on the hypothetical continuum are identified as pain and pleasure, representing the broad selection of subjective experiences related to each. The continuum extends from one end, representing the background emotional states assumed to be associated with severe traumatic emotional injury, through average, everyday background states (here called optimal) and extends to the other end, representing peak, highly pleasurable emotional background states. It intends to reflect all the in-between states a person might encounter in a lifetime as relative points on the continuum. Thus, it reflects many dimensions of the background states experienced as emotional illness and health. (See Figure 1).
The horizontal line represents a continuum of background emotions that people likely experience in a lifetime. It does not intend to describe the actual lifetime experiences of any real person’s or culture’s experience; rather, it represents the range of potential experiences of some mythical average person (or of the average of many persons), whose lifetime(s) of background emotions might range from the worst pain to the greatest pleasure.

The normal or bell curve is overlaid on the continuum, representing the statistically predicted variation in any one person’s, or the average of many people’s, emotional experience. As for any of many human characteristics, the model displays the expected percentage of experiences expected to fall within the upper and lower three standard deviations from the mean. At the furthest edges of our continuum are experiences that represent the most extreme background feeling states human beings ever have. It is not intended to represent a linear model, requiring step-by-step change from pole to pole, but does represent relative frequencies and differences between feeling states.

This continuum deviates from Damasio’s (1994) description of background states. He does not see them as having the potency implied by the poles on this continuum and says they are “neither too positive nor too negative” (p. 150). However, as a therapist, I would counter that background emotions that endure after a traumatic or peak experience can be and often are relatively stronger than midrange or everyday background emotions. Many therapy clients would agree. It is the striking contrast of these more extreme emotional experiences resulting in more lasting background states than those of more average, everyday states that leads to their identification as highly positive and memorable (peak) or highly negative and memorable (traumatic, injury). It is frequently the lasting quality and the degree of distress caused by painful background emotional states that leads people to seek psychotherapy or medical intervention for them.

The continuum of feeling states, then, shows the range of emotional experiences most people might be able or expected to encounter in a lifetime (See Figure 2). It is important to acknowledge that individual people will have experiences that vary widely, as will groups and cultures over time; the model attempts to capture and reflect a possible, average range of human emotional sensations. Similarly, the discussion is primarily related to egoic emotional health. How this relates to the transpersonal is not yet clear. While much of the time our background emotional state is at an optimal level, more extreme states may result from stronger reactions of the autonomic/central nervous system (ANS/CNS) to stronger stimuli; those that are more potent for the organism may result in stronger reactions and potentially longer

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**Figure 1.** Continuum of background emotions experienced in a lifetime.
lasting effects. For ease of communication, this article will refer to this system as the ANS because it is the one most frequently cited as having two branches, the parasympathetic nervous system (PNS) and the sympathetic (SNS). Recognizing the range of possible background emotional states and their relative frequencies, it is now possible to consider the question of how emotional states change.

**How Do Emotions Work?**

How emotions work is also largely unclear. Wilhelm Reich (1949) is one of the few researchers to offer a more comprehensive theory of the dynamic, interdependent nature of emotional change, work that has more recently been corroborated by others (Siegel, 2010; Damasio, 1999). Reich saw the human biological system as self-balancing and self-correcting—a phenomenon widely known in the medical field as homeostasis—and he included the human emotional system in this understanding (Reich, 1949). He called what he saw as the dynamic use of psychic energy the “libido economy” (pp. 12-15).

Reich (1949) observed that all biophysical organisms have two primary reactions to their environment: moving outward, such as an amoeba reaching out with a pod.
searching for food, and the counter movement of moving inward, retracting in response to fear, danger, or pain—the organism drawing back into itself and away from the danger. Reich called the outward movement *expansion* and the inward movement *retraction*. Mobility, then, a primary characteristic of life itself, is an organismic expansion resulting in exploration, pleasure, or self-gratification when the organism is not restricted by pain or danger. The human body also reaches out in exploration, expanding and relaxing in pleasure, and withdrawing, and constricting back into itself or physically defending against pain by retracting and contracting. Thus the dynamic continuum of movement and response to emotional experience extends from expansion, experienced as pleasure, to contraction, experienced as pain (p. 360). As he noted:

Literally, “emotion” means “moving out,” “protruding.” It is not only permissible but necessary to take the word “emotion” literally in speaking of sensations and movements. Microscopic observation of amebae subjected to slight electric stimuli renders the meaning of the term “emotion” in an unmistakable manner. *Basically, emotion is an expressive plasmatic motion.* Pleasurable stimuli cause an “emotion” of the protoplasm from the center towards the periphery. Conversely, unpleasurable stimuli cause an “emotion”—or rather, “remotion”—from the periphery to the center of the organism. These two basic directions of biophysical plasma current correspond to the two basic affects of the psychic apparatus, pleasure and anxiety. (1949, p. 358)

Fundamental to neo-Reichian therapies is that of the breath as the source of muscular contraction and release (Lowen, 1975), an understanding that has been validated by research during the past half century (e.g., Ogden, Minton, & Pain, 2006; van der Kolk, 2014; van der Kolk, McFarlane, & Weisaeth, 1996/2007). When the organism is in danger, the sympathetic nervous system (SNS) naturally “charges” to respond to the danger, and among the first signs of this are increases in the breath as preparation for life-saving maneuvers. This reaction of the SNS is fueled by adrenalin and other powerful stress hormones, which enable the life-protecting responses needed for flight or fight (Herman, 1992/1997; Rothschild, 2000; van der Kolk, 2014). When the danger has passed, the charge naturally dissipates and the body chemicals eventually return to normal levels, releasing both musculature and breath, a process apparently stimulated by the release of corresponding neurochemicals from the parasympathetic nervous system (PNS) (Ogden et al., 2006) or by the PNS “brake” reaction which retards the output of stress chemicals following a surge from the SNS (van der Kolk, 2014).

The purpose and activity of the sympathetic nervous system (SNS) is well known and frequently written about in the research literature. It is “responsible for arousal, including the fight or flight response...it moves blood to the muscles for quick action, partly by triggering the adrenal glands to squirt out adrenaline, which speeds up the heart rate and increases blood pressure” (van der Kolk, 2014, p. 77). The second branch of the autonomic nervous system (ANS) is the parasympathetic nervous system (PNS), which receives significantly less press. It “promotes self-preservative functions like digestion and wound healing. It triggers the release of acetylcholine to put a brake on arousal, slowing the heart down, relaxing muscles, and returning breathing to normal” (p.77). The parasympathetic is associated with

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feeding, shelter, and mating activities, which are linked with increased levels of oxytocin and vasopressin, hormones known to induce calm, connected feelings.

The balance between these two systems can be tested through heart rate variability (HRV), a measurement of the fluctuations between inhalation and exhalation as they affect heart rate. If both the brake (PNS exhalation) and the accelerator (SNS inhalation) are functioning well and in balance, the HRV will show flexibility and balance (van der Kolk, 2014, p. 77). However, recent research does not support a simple homeostatic or balance relationship between the two sides of the autonomic nervous system (ANS). As Porges (2011) suggests, “The primary parasympathetic influence to peripheral organs is conveyed through the vagus, a cranial nerve that exits the brain and innervates the gastrointestinal tract, respiratory tract, heart and abdominal viscera” (p. 264).

Stephen Porges’ (2011) work suggests that the autonomic nervous system (ANS) is a hierarchical system. His Polyvagal Theory further supports the idea that neural regulation is strongly related to health, learning and social behavior as well as to the social engagement system. The increasing complexity of the ANS does not negate its fundamental SNS activities, and fight or flight responses are among the most well known, nor its fundamental PNS correlates such as safety and maternal nurturing behaviors.

According to Reich (1949), when the body is exposed to habitual or chronic muscular holding, over time it becomes less elastic, and the contraction develops into a band of tension in the body, which he called *blocks* and *armor*. Reich noted that chronic contractions in the musculature of the body could eventually result in physical illness due to the recurrent release of stress-response chemicals without resolution to resting levels. Esch and Stefano, (2004) echo Reich’s notion of armor and the influence of stress on health: “This failure of ‘healthy’ biochemical signaling pathways to return to normal – resembling the chronic stress pathophysiology – may be followed by hazardous health consequences over time” (p. 239).

Stress-related illnesses were detailed as early as 1975 by Benson in *The Relaxation Response*, work that has been developed and extended by many other people (e.g. Carlson, Speca, Patel & Goodey, 2003; Davidson et al., 2003; Kabat-Zinn et al., 1998; Reibel, Greeson, Brainard, & Rosenzweig, 2001). The popularity of the idea that stress and illness are intimately connected can be demonstrated in a quick Internet search of the Amazon.com listings for books related to stress and its effects on health, currently numbering more than 30,000. However, there are difficulties in proving causation. The articles cited in this paragraph demonstrate the relative ease of showing the effects of mindfulness on health efficacy, rather than stress on ill health.

Reich’s intention was to create a successful psychotherapy that released the *armor* or bands of tension in the body. He used pressure or physically manipulated the client’s chronic contractions with his hands or through having clients hold difficult physical positions. This was intended to increase the contraction and push the energetic charge of that tension beyond the level of the contraction that had become...
habitually and chronically contained in the body. He believed this would increase the “charge” of the contraction to the point of release, which when released, would result in a more complete “discharge” of the tension (Lowen, 1975).

The same principle is used in massage, yoga, stretching, biofeedback relaxation, and other forms of relaxation. Most of our bodily functions have this same loop: a buildup of tension (hunger, sleepiness, inhaling), which is ultimately discharged (when we eat, sleep, or exhale), resulting in a sensation of release and subsequent physical and emotional sense of ease or pleasure. A discharge of tension in turn releases energy for use by the organism and keeps the energetic flow at an optimal level so that the organism can go about its life. In human terms, it means releasing energy to the optimal level for learning and for meeting the ongoing human needs for survival and actualization.

The human organism has two survival mechanisms according to Lipton (2005), which are growth and protection. Organisms can gravitate toward or move away from, but they cannot do both at the same time. When the organism is in a protective mode, it restricts growth. Growth requires openness between the organism and the environment. This is also known as Dharmakirti’s Psychological Law (Dalai Lama, 2005). Dharmakirti was a 7th century philosopher-monk who noted that when one side of any polarity is stronger, the other is weaker. So, if one works to strengthen the positive, one correspondingly weakens the negative, thus effectively bringing about transformation in one’s thought and emotions. In the Dalai Lama’s (2005) words:

Like other Buddhist thinkers before him, Dharmakirti invokes what could be called a “psychological law” in that he sees various psychological states, including the emotions, as a field of forces in which opposing families of mental states interact in a constant dynamic. Within the domain of the emotions, there might be a family consisting of hate, anger, hostility and so forth, while in opposition is a family of positive emotions, like love, compassion, and empathy. Dharmakirti argues that if one side of any such polarity is stronger, the other is weaker in any given individual at any given time. So if one works to increase, reinforce, and strengthen the positive groups, one will correspondingly weaken the negative ones, thus effectively bringing about transformation in one’s thoughts and emotions. (p. 146). . .This law whereby two opposing states cannot coexist without one undermining the other is the key premise in the Buddhist argument for the transformability of consciousness . . . (p. 146) Dharmakirti goes even further and suggests that, unlike physical abilities, the qualities of the mind have the potential for limitless development. (p. 147)

This underlies one of the key teachings in Buddhist psychology. Unlike Western psychology, Buddhist psychology encourages the avoidance of negative emotions and simultaneously cultivates positive states of mind. Some Western scientists have empirically demonstrated this phenomenon: “Neurobiological data suggest that once emotional pain pathways ‘fire,’ the frequency of future firing of those same pathways increases. This ‘kindling’ effect is thus a central object of intervention in DBT [Dialectical Behavior Therapy] approaches to suffering” (Marra, 2005, p. 7).
Positive and negative emotions seem to function differently; both function in accordance with hypothesized survival needs during human evolutionary history. Fredrickson (2001) suggests a “broaden and build” theory of positive emotion to explain how positive emotions function differently from negative emotions. While negative emotions seem linked to a specific action tendency (such as fear with the urge to escape and anger with the urge to attack), positive emotions, in her view, have “vague and underspecified” tendencies. Positive emotions broaden people’s momentary “thought-action repertoires,” generating greater likelihood of increased personal resources overall. She sees these personal resources as “durable and [they] can be drawn on in subsequent moments and in different emotional states” (pp. 219-220). Fredrickson et al., (2000) recommend the “undoing” hypothesis, which posits that positive emotion dismantles the specific action sequences generated by negative emotion. They also note that some authors have suggested parasympathetic regulation as a potential explanation.

So, What is Emotional Illness?

Emotional illness is that painful tension and contraction in the body-mind due to the negative assessment of a stimulus causing the sympathetic nervous system (SNS) to release the neurochemicals that orient the body to prepare for danger or threat that lasts beyond the need for the preparation for danger or that results from responding to ongoing danger. Experiences are directly connected to the emotions they generate as the brain is activated and assesses whether the experience is threatening for the organism or not. These emotions then translate into background sensations in the body that are either pleasurable or painful or neutral based on whether they result in an overall feeling of expansion or contraction in the body, or whether they return the body to its pre-danger state of functioning. Background sensations have intensity charges and can be fluid and malleable or contracted and intractable.

Depression, stress, and anxiety in this model are related to the branches of the autonomic nervous system (ANS) responsible for the integrity of the body. When the ANS is overwhelmed by the degree of the danger or the constancy of the threatening insult, it seems to either overcharge (hyperarousal) or undercharge (hypoarousal) the energetic current, resulting in the background emotions of anxiety or dissociated depression (Ogden et al., 2006; van der Kolk, 2014).

To include these concepts in the model, the continuum of human emotional background experiences from pain to pleasure is reflected, as are the charge and discharge of energy. The physical reaction to emotional pain, as a contracted and contained state of energy withheld for healing, can also be added to the model (See Figure 3).

Summary of What Emotions are and How They Work

Even though there is substantial variation in the ways that scientists have looked at emotional health and illness in the past, recent biological definitions suggest that
emotions may be the basis of our sense of self, health, and well being. Autonomic nervous system (ANS) reactions to incoming stimuli send neurotransmitters throughout the body, which result in the internal experience of emotions; those resulting in contracted body-mind states are experienced as pain. When the corresponding neurotransmitters of the parasympathetic nervous system are released, the body-mind experiences relaxation and a sense of pleasure and expansion. The movement of emotional responses to stimuli is typically smooth and complete, resulting in complete energetic charge and discharge and a return of the energy to the optimal level. However, when the system holds on to energy in a chronic retraction beyond the need for the response to protect against a dangerous threat, it results in the background feeling experience of emotional illness. The continuum and overlaid bell curve demonstrate the relative likelihood of emotional states from pain to pleasure, show the movement from one state to another in

*Traumatized (dialectic of anxiety to dissociated depression in PTSD; response of the “old vagus” (Porges, 2008)

Perception of danger or threat or negative stimulus
Sympathetic Nervous System (SNS) ↔ (charge) pain
Tension charge

Perception of positive stimulus
Parasympathetic Nervous System →(discharge) pleasure
Tension discharge

Figure 3. The continuum of background emotions experienced in a lifetime related to ANS (autonomic nervous system) functions.
relative levels of contraction or expansion, and offer labels for the relative categories of internal body-mind states.

What is Emotional Healing?

Egoic emotional healing results from the release of the contraction and containment of energy back to the optimal, more neutral, range of energetic expression. Healing restores the organism’s ability to experience any emotion on the continuum in the next moment. Healing has occurred when the organism is not withholding energy to prepare for or deal with a current or past threat or danger.

As in Reich’s (1949) and Lowen’s (1975) psychotherapeutic work, the tension of a psychological wound can be increased in the body-mind to build the charge so that a more complete discharge is possible and a resultant sense of fluidity and ease can be restored. The contraction can be discharged through a variety of activities. However the discharge happens, health is a return to the optimal range of the model with the capacity to feel all of our feelings from end to end on the continuum in response to the next moment’s stimulus. Tension is discharged. An optimal flow of energy is restored, and the body’s ability to respond efficiently and effectively to each new, incoming stimulus is restored.

Healing essentially reflects the degree of relief in the body-mind and breath to again approach the freedom of experience of which the body is capable. There are many routes to relief: some people are most relieved through somatic discharge, others through emotional discharge; still others get relief from cognitive processing. What seems to work in every case is increasing the intensity of the contraction to discharge so that the energy contained in the contraction is released back to the center of the continuum. This requires an attention to the contraction and awareness to the pain in the present moment to allow these difficulties to be felt fully and ultimately discharged through a recognition that the threat has passed and the pain can be released.

This description of how emotions are healed parallels the well-known work of Peter Levine (1997) and how the procedures of Somatic Experiencing seem to “reset” the inherent capacity for self-regulation through tracking the felt sense experience, titration, pendulation, etc. Hakomi and sensorimotor therapies also use the body to re-regulate emotional dysregulation (Kurtz 1990; Ogden, Minton, & Pain, 2006; van der Kolk, 2014).

What Does Emotional Health Look Like?

Egoic emotional health is restored flexibility and adaptability. Health brings access to the full range of emotional sensations available to being human. The homeostatic function is elastic, and most of a person’s time is once again spent in the optimal area portrayed in the model where there is abundant energy to grow, learn, and create as people do when they are healthy. Emotional health means having energy to use for whatever purpose is needed, for various creative outlets, and for just
living life. Healthy energy is not stuck; it is fluid, and open and full of changing human expressions in response to each new stimulus from the environment. Emotionally healthy people are resilient.

The model suggests that emotional health is fluid and adaptive and that the emotionally healthy person is appropriately responsive to every possible new experience. People can still access pain and automatically respond to danger to save their lives when necessary. However, they can also experience pleasure and allow its healing qualities to refresh and sustain them. They continue to look forward to new experiences, and they relish growing, living, and loving. There is a sense of openness and contentment, not constantly blissful but generous and spacious.

The state of being without stress may almost be unknown in today’s world; however, it might be well worth rediscovering it. The closest many people come to experiencing it may be when they practice lessons learned from the Eastern esoteric communities: living in the moment, leaving their chattering mindlessness and entering the actual felt experiences of their bodies and the witnessing of their consciousness. Such practices include mindfulness, yoga, meditation, and the like. These practices stimulate transpersonal growth and encourage interest in transpersonal states. Transpersonal experiences are fairly common among humans, but the positive qualities they inspire fail to be converted to traits without first developing the foundation of egoic emotional health.

Emotional health is not characterized by experiencing constant positive emotions. Attempts to make positive sensations last may be related to tendencies toward addiction (Esch & Stephano, 2004). Finding varied levels of positive emotions pleasurable and regularly engaging in activities that are secondarily fulfilling are also indicative of emotional health. In contrast, both denial of the sensation of feeling and contractions in emotional fulfillment may be indicative of armor that masks underlying pain and illness.

This concludes the general overview of the model of emotional illness and health. In summary, egoic emotional illness occurs when the sympathetic nervous system (SNS) responds to a perceived threat and the background emotions that result endure beyond the organism’s original response to the threat and even beyond the need for a response to the threat. Sometimes the energy from emotionally stressful, injurious, or traumatic experience becomes held or trapped instead of being released and recycled. The contraction results in a person’s internal experience of emotional illness. It results from the pain of the tension and contraction held in the body-mind. The intensity and duration of the contraction indicate the degree of illness.

People feel emotionally well when there is a release of the contraction, a return to an internal sense of expansion and relaxation, and a return to the optimal central range of sensation. They “get better” and feel emotionally healthy when the energy of the body-mind has been restored. Their background emotion changes to one of ease and flow when there is a release of the contraction, and so getting better is both the instantaneous experience of release and the long-term resulting feeling state of ease and well being. Given the chronic state of stress most people endure in the
industrial world, “getting better” might come and go over time as multiple stressors and contractions develop and dissipate. A general egoic goal is to continue to generate and encourage a feeling of personal health and strength, contentment, and interest in one’s own life; as the ego matures, an expanded, transpersonal well being becomes possible, including interest in service to others and in topics and activities related to the spiritual, rather than the material world.

People are emotionally healthy from a personal perspective when they are able to respond to any new stimulus with a fluid, adaptive, appropriate response and are not distracted from the activities of their lives by a feeling of emotional malaise resulting from energy being withheld in the body’s contracted state. This level of emotional health sets the foundation for expansion into transpersonal areas of growth, including seeking a spiritual life, community, and opportunities for service.

Transpersonal and Transformational Integrations

The title of this model, “Toward a Transpersonal Model of Psychological Illness, Health and Transformation,” indicates that in addition to being a model of egoic emotional illness and health, it is also transpersonal and transformational. “Getting better” requires releasing the energy from a contracted state (withholding energy for healing and protecting) to an expansive state (renewing and sustaining energy for living). This next section of the article describes how transpersonal theorists and clinicians, in particular, can integrate and apply the model and its transformational concepts of growth and change in their healing work.

How is this Model Transpersonal?

As suggested in the introduction of this article, the model lends itself to, and supports, a transpersonal theoretical stance. Key assumptions of the transpersonal perspective include: (a) human beings are by nature intrinsically healthy, (b) human beings are best viewed and treated psychologically through a holistic lens, (c) human beings are limited by their beliefs about who they are, (d) human beings can transcend their egos to experience higher levels of trans-egoic consciousness, (e) emotional illness as it is defined in the DSM —5 often refers primarily to pre-egoic and damaged-egoic states of being, and (f) transcendence of healthy egoic consciousness is by definition transformational. The article next examines each of these assumptions as they relate to the present model.

According to transpersonal theory, human beings are by nature intrinsically healthy. In contrast, the emphasis in traditional Western psychology has been on pathology. As the psychology field has named and defined symptomology for seemingly endless variations of emotional illness in the DSM, advertising, and general cultural experience, humans are not-so- subtly being defined as primarily ill in one or more ways. There is little discussion in the field today, particularly in the DSM —5 (APA, 2013), of what health is or how common it is. As a result, people may tend to see themselves as mainly inclined to deficiency and illness. In contrast, the current model provides a view that human emotional experience has a broad
range, from positive to negative, with the majority of our experience in the neutral to positive healthy range. Illness thus becomes the exception, something that is not expected to consume our whole lives to “get fixed” or be the definition of “who we are.” The model, then, supports the transpersonal view of human beings as intrinsically well, healthy and functional.

According to transpersonal theory, human beings are best viewed and treated psychologically through a holistic lens. The model used here is based on a definition of people as whole beings. Emotion, experience, meaning, relationship, and feeling are all bound together with an overall sense of self. Reducing these central components of humanness to isolated mechanisms gives people very little direction in how to intervene in their own unhappiness. In contrast, the image and construction of humans as whole beings with experiences that traverse wide expanses of energetic rhythms allows them to be a bit more generous with themselves and to expect a bit more variety and fluctuation in their passing emotional states. People can imagine riding and witnessing the experiences of their lives instead of concretizing them and believing there is no way out of what seems to be permanent pain. Using the model, humanness includes a wide range of emotional possibilities, and people may be able to better appreciate the differences in their subjectively shifting states. This is a much more positive view of human life than the pathology view and also provides a partial understanding of the success of the Buddhist constructs of witness consciousness, mindfulness, meditation, and maitri (loving-kindness) as strategies for self-intervention.

Human beings are limited by their beliefs about who they are. When they are besieged by media images of other people who seem so much happier than they are, people tend to think something is wrong with them or that something is missing in their lives. Television advertisements, for example, remind viewers constantly of all the illnesses they might have, both physical and emotional. Every other television commercial recommends that we ask our doctor to give us a prescription, even if it is bad for our liver or causes birth defects. Fortunately, medication is just a phone call away. By contrast, according to the current model, humans are beings experiencing a wide range of constantly shifting emotional states. This view of human essential health and strength, with occasional forays into the challenges of life that are expected—and even desired—in a normal life, gives us much more to value and less to fear in “being with the way things are.” From the view of the current transpersonal model, emotional discomfort is placed in the larger perspective of a self that is encountering a rich and varied set of experiences. The model broadens the perspective significantly and suggests that current states of emotional discomfort might mean experiencing a transition that could be growth producing and does not necessarily mean that a mental disorder, such as bipolar disorder, schizophrenia, or a personality disorder has occurred. This model, then provides an expanded view of human functioning and creates an expectation that is larger and more varied than the current media-driven or medical-driven models of emotional illnesses identified as permanent pathologies that, at the least, require medication and at worst are a “life sentence.”

Human beings can transcend the ego state and discover higher levels of trans-egoic consciousness; this may be one of the larger purposes of our lives. The model may
help to balance the self in healthy ego states and learn to create and strengthen
people’s capacity to enlist and practice egoic health. While this is not necessary for
experiences of trans-egoic realities, it is a precursor to developing a stronger
ongoing relationship with the transpersonal self and gaining more experience with
generating one’s own access to transcendent spaces. The model provides a map to
understand the development toward the transpersonal that naturally results from
widening the perspective from illness to health and from living in a healthy state
instead of a dis-eased one. In addition, when people are healthy but unhappy, it is a
perfect time to find out whether the work they are doing is truly the mission they
are on earth to perform or the relationship they are in is the right one for them.
Listening to the deepest part of ourselves and living life from that place is not often
coupled by the consumer culture, but it is far more satisfying.

Emotional illness as it is defined in the West and by the DSM–5 (APA, 2013) often
refers to pre-egoic and damaged-egoic states of being. The proposed model, in
contrast, defines emotional illness as also occurring during transitory periods in a
healthy life, induced by occasional unpleasant—and sometimes severe—experi-
ences to which human bodies respond by tightening up and resisting. Fearfulness
and a lack of education about emotional health in this culture serve as a kind of
everyday threat that makes people more likely to contract. Malfunctions of our
bodies notwithstanding, much of the emotional pain people experience can be
lessened by surrendering to it and allowing time to listen to its meanings.
Acknowledging painful events and losses and recognizing them as powerful, and
potentially transforming, moments in our lives is a sign of health that is often not
achieved through the current medical definition of emotional health.

How is this Model Transformational?

Finally, transcendence of egoic consciousness is by definition transformational, and
this is a central goal of transpersonal therapy. Reconnecting each person with their
birthright and reinstating the capacity for reconnection with their foundational
spiritual nature is among the most important tasks of therapy, especially for
transpersonal therapists. This reconnection reminds people of the importance of the
life they are living and also helps them to be more tolerant of its sometimes
mundane everydayness as well as its moments of deep pain and transcending
happiness. The proposed model reminds people that releases of energy can happen
at any time and expand them to any degree. It does not necessarily require years of
psychotherapy and multiple cocktails of medication. In a release of energy, people
can experience peak moments as likely as not, and this shift in perspective brings
greater excitement and enjoyment of what is possible.

Transpersonal therapists attempt to refocus or reframe clients’ views of who they
are and why they are alive. Using the natural transitions in people’s lives and their
emotional symptoms of pain and dis-ease to help them refocus on their spiritual
development is a uniquely transpersonal counseling endeavor. Using this model,
clients are able to imagine and remember themselves in their peak moments and
recall their pleasures as clearly as their pain and tragedies. They are more likely to
see their emotional distress symptoms as voices from their own spiritual core and as
a call to a higher level of spiritual contact. They are able to return to questions of the quality of the life they are living, the nature of real happiness, the purpose and meaning of their own lives, and their desire to give to others.

When we are on a healing trajectory, the next step is confronting transpersonal truths. Life is defined as having more dimensions than being a star or making more money. Using this model, clients are more likely to look inside themselves for the answers to their deepest questions, and to treasure both the painful and the pleasurable.

The proposed model promotes a transpersonal perspective because it provides a vision of humanness that is as open and expansive as it is contracted and fearful. Focusing on health, refocusing on concerns of personal spiritual importance, and appreciating the present moment even while recognizing it is also a transition to the development of fuller potential allows people to experience the beauty and magnificence of their own personal experiences of life, and not just try to get away from the pain, sadness, or tragedy.

**Two Clients' Stories Using the Transpersonal Model as a Treatment Intervention**

**Mark's Story**

When Mark called for a therapy appointment he said that his mother had encouraged him to call and had given him the phone number. He was, he said, not sure why his life was so seemingly out of control. He was really in trouble and needed some help.

During the first session, Mark disclosed that he and his best friend were using cocaine “all the time.” They had been working construction during the day and getting high every night for at least a year. Lately they had started getting high at lunch and even before work. Mark was 22 years old.

His mom had been alcoholic when he was growing up, and there were lots of times when he would cover her with a blanket and go to bed because she was too drunk to wake up and walk to her own bed. She was also really angry, he said, and it was not unusual for her to break things, yell at him, or even leave him home alone for long periods. Now that she was sober, she was really sorry and felt guilty about Mark’s struggles to “get his life together.” No, he said, she did not know about his cocaine use, and she was still really worried about him.

Mark was a big, burly young man. He had come to therapy in his big work boots and his overalls. He wore a cap most of the time and rarely made eye contact. He thought he might never get off cocaine and was worried that he might die one day.

One of the most important questions I asked Mark during the first sessions we had together was why he thought he was “on the planet.” It was one of the rare times during the first sessions that he looked at me from under his cap and actually
smiled. What a peculiar question, he must have thought. Naturally, he did not know why he “was on the planet” and just shrugged, but I knew by the way he had looked at me that he would think about the question later. Meanwhile, we talked about the stress and trauma he had lived with as a child and young man and how that had affected his autonomic nervous system (ANS). We considered whether that had any relationship to his current drug use. We talked about what health would look like for him. He was not sure what it was supposed to look like or feel like, but he was pretty sure that what he was doing was not it.

I showed him the model, and we talked about pleasure and pain and how our bodies cope with our experiences. He related that at first cocaine made him feel pleasure, but that was not happening as much anymore. Now it was just making him feel bad, but he wanted it all the time.

One day not too long after we had started talking, he came to his session and seemed a little lighter. He looked at me and smiled and said he thought he had the answer to my question. After a few seconds of teasing me with his dramatic delay, he said, “I’m a Viking!” I confess I was clueless, quickly searching my mind for what on earth he might be talking about. “What is a Viking?” I asked. “You know the guy on a big boat with a hat, sailing around in the ocean.” He was grinning and chortling, just thinking about himself as a Viking. “Funny,” I said, “you do look like a Viking!”

Mark lost his job and he stopped coming to therapy soon after he had this vision of himself as a Viking. A year later I got a phone call from his mother. She left a message on my answering machine. “I just wanted to let you know that Mark is on a big boat outside of Norway. He sent a picture, and he looks just like a Viking. A happy Viking! And, he is off cocaine. He is sailing instead.”

Carolyn

Carolyn was a 35-year-old woman who had been sexually molested by her older brother from the time she was 9 to when she was 12 years old. She felt betrayed by her brother and abandoned by her parents who failed to protect her from him and who she believed deliberately left her to “fend for herself.” She had never had a long-term intimate relationship, but she thought she was a lesbian. She had had a series of short-term affairs with other young women who seemed, she said, as frightened and desperate as she felt. This also made her sad and distressed. She did not want to be a lesbian and was worried that what had happened to her with her brother had “made her” a lesbian. She believed it was morally wrong for a Christian to be a lesbian, which complicated her situation dramatically.

Carolyn sought therapy because of an overwhelming sense of futility and despair. She often thought of committing suicide and had trouble finding reasons to keep living. She did not see any end to her misery, and she felt trapped by the misery of her life following her childhood trauma. She felt that even God had abandoned her, and she did not see any way out of her own vision of herself as a “God forsaken” person.
Throughout our sessions, we talked about Carolyn’s life experiences and her feelings about them frequently in the context of her depression. In many different conversations I asked her what she wanted from her life, what would make it worth it to wake up every day, what would make her happy and give her pleasure. She was adamant in her response that there was nothing—nothing that she could think of.

I shared the model with her, and she could easily point out her background emotions as she fluctuated between bouts of terrified anxiety and crippling depression. She could see that her current lived experience had been reduced to the lowest quadrant on the diagram. She did not remember having much satisfaction or pleasure. In fact, she stated, those were actually feelings she avoided and did not want to feel. They made her depression worse, she said.

I explained to her that having feelings on only one side of the model ensured that those feelings would continue to get more pronounced, and the feelings on the other side of the continuum even less likely to occur. I told her that people can feel either relaxed and pleasure or anxious and in pain, but not both at the same time. I explained that one way to move out of the pain was to experience and learn to tolerate positive feelings. Feeling satisfaction and pleasure would stretch her emotional muscles and reset her body’s inclinations toward a more balanced and homeostatic dynamic. I told her about the neural pathways and how they deepened and became more and more likely with use, but it works for good feelings as well as negative ones, and she could use that knowledge to help herself feel better.

Her homework was to practice feeling happy, satisfied and pleased and to increase her tolerance for those feelings. She was required to experiment with and find things she liked to do and find things from inside herself that she “wanted.” Her resistance was intense. These homework assignments were almost unthinkable to her. Meanwhile I encouraged her to continue to explore different churches and find one that “felt good” to her. We talked about her view of God and forgiveness and that perhaps the childhood God she believed had forsaken her was not the whole God she would come to know as her adult self.

Finally, one day she said, “I just don’t know what you want from me!” I said, “I just want you to feel good, be happy, find out what you want in your life and have a reason to live another day!”

She began to cry, and she said, “I just want to be loved. I want to love someone who loves me. I want to make a home and a life with someone I love.”

The “someone she wanted” was currently engaged to a man, and we agreed that the likelihood of this dream coming true for her was slim. But the moment was profoundly transformational. Carolyn had finally broken through her own despair enough to want happiness, to be willing to imagine that she could have some for herself in spite of her childhood trauma. We continued to talk about and work through the grief she felt from the experiences she had had in her life, but now there was a new image, that of happiness and pleasure of sharing her life with someone she loved.
Within six months of claiming this right to imagine happiness, the “someone she wanted” had broken up with her fiancé and was agreeing to a date with Carolyn. Still together today, they are happily making a home with many cats and many friends. They are also active members of a church, performing outreach to the homeless and forsaken.

Helping Relationships Students

Each year I teach a course in Naropa University’s Transpersonal Counseling Psychology Department for first-year masters-seeking counseling students called Helping Relationships. One of the topics I introduce is how to work with the after-effects of trauma. I use the model described in this article to teach the students that traumatic and peak experiences are possible in everyone’s life, though they are by definition rare and profound.

Most of my students have had peak, transformational experiences, and many have had transforming traumas as well. Students practice sharing these stories with each other and learn to listen to the varying ways that each person has of verbalizing and attempting to communicate the impact of these experiences.

Questions I always ask students are how often and with whom they have shared their extreme experiences in their lives. Most have shared the positive, powerful impacting events with only one or two people on one or two occasions. Interestingly, they have shared the traumatic experiences more often and with more people. It is possible that they use sharing of their traumatic experiences as ways to create deeper intimacy with those they care about; however, they have had less experience with sharing peak experiences, even with their closest intimates. It is most likely they will share peak memories with others in an environment where it is invited by the topic (workshop) or by the relationship (teacher, mentor, guru), but there is sometimes a hesitancy to share with everyday friends.

One of the classroom experiences I use is to have students rate their current background feeling on the model’s continuum and then share their stories with each other. After they share different types of experiences, I have them rate their internal sensation again. Sharing both positive and painful experiences brings relief and improved positive sensations in ratings on the continuum. Yet, in the current culture, there seems to be a preference for identifying more with our traumas and pain. Students have said they feel silly sharing their most positive profound experiences. They state that others often do not “believe” them, how hard it is to talk about these experiences because they are so hard to describe, and they are worried that others will think them “crazy” or, worse, “weird.”

Using the proposed model, I am able to help my students “normalize” the range of possible emotional experiences they have had and learn to ask clients about experiences on both sides of the continuum. They practice helping each other move, change, and transform their positions on the continuum and in their background sensations. They learn to listen more carefully to internal body cues and articulate more clearly what their subtle feeling experiences are and how to
name and describe them. This then becomes a rich foundation for them to be able to relate to their clients, be with their pain and their pleasure, and appreciate both without reinforcing the cultural tendency to cling, attach, or hang on to what has happened in the past, whether positive or negative.

I also use yoga poses and metaphors to reinforce these concepts. For example, the concept of “reintegrating back to center” is a tool I learned from my first yoga teacher. As a person is performing a yoga pose to the extent their body is able, the instruction is to “go to the edge of the pose, take a deep breath in, and then exhale into the edge of the pose before releasing it.” The person then releases the pose and returns to a centering pose such as tadasana or mountain pose. Here, students are advised to “allow your energy to be re-centered, watch your breath return to normal, and integrate the new sensations from the pose into the body. Notice how you have changed.”

In the same way, clinical training with this model can teach counselors to encourage clients to feel, connect, relate, and share their most important life experiences with others in relationship. They can also teach clients to release their feelings back to center, allowing the breath and body to integrate new experiences and re-invigorate themselves in the telling and re-telling of their life stories. They learn to become someone different and more expansive from each experience; they notice how to grow.

**Relevance to Researchers**

Research on the efficacy of psychotherapy interventions is complicated and difficult to control. Research with this model and its impact is also likely to be challenging. As in “reframing,” what this model seems to provide is a different perspective of people’s emotional wounding and a different perspective of what might be required to heal. One research design might present the proposed model to one group of people in a psychoeducational setting and measure their sensations of satisfaction and pleasure, their motivation to provide positive experiences for themselves, and their perceived degree of emotional wellness or illness both before and following the presentation. Another group would be measured following the presentation of some neutral model. A third group could be exposed to the DSM model or television advertisements related to mental illnesses and comparisons could determine whether there were differences in the ways the groups perceived their ability to feel happy, their motivation to be happier, or their belief about how easy it might be to change their background states.

Another fruitful area of research might be to validate whether people have the range of emotional experiences described in the model, whether the labels for the points on the curve are meaningful and useful, and to what degree different people identify with the significant deviance areas within the curve. To my knowledge, there are no other continuum models placing both positive and negative emotions on the same orientation, attributing them to different functions of the ANS (autonomic nervous system). While research seems to support this possibility, it would be useful to know how accurately such a model reflects these internal events.
While the pain part of the continuum has much research to validate it, the pleasure side has far less research to clarify it. It would be important to understand the range of PNS (Parasympathetic Nervous System) reactions and how they are ordered. Is a peak experience related to relaxation? Is pleasure stronger than satisfaction? Are there complementary physical markers for the pleasure continuum as exist for the pain side?

An area of research that is of interest to transpersonal psychotherapists and researchers is whether this model is a “clinical embodiment of transpersonal principles that have the potential to bring transformative energies into the practice of psychology” (Friedman & Hartelius, 2008, p. 63). As a therapist for the past 25 years, I have often been struck by the ways my clients have thought about emotional health and illness. I would not abandon the need for a therapeutic relationship or the need for clients’ stories to be heard, witnessed, and shared. Yet, it also seems worthwhile to help clients reframe their tragedies into launching pads for future growth and happiness. The proposed model helps communicate the concept that energy moves according to basic organismic needs, like seeking pleasure and avoiding pain. It seems to provide some permission to be healthier and let go of hurt. It suggests that people can shift the charge of energy at any moment from one pole to the other and that they can learn to experience and release feelings much more readily than they might imagine—without trivializing or minimizing their most profound experiences. Yes, we need to grieve, and we also need to laugh, love and enjoy our lives. This model has helped me provide interventions that encourage transformational, adaptive responses to emotional wounds by increasing pleasure to meet and treat great pain.

**Summary**

A Transpersonal Model of Psychological Illness, Health, and Transformation has been described that illustrates one view of what emotional pain is, how it can be healed, and what egoic health looks like. A continuum of hypothetical lifetime emotional experiences was posited to depict the range of felt experiences from traumatic to average to peak experiences. The continuum is overlaid by the statistical normal curve used to describe many human characteristics; it shows the range of emotional background experiences from average to exceptional with suggested percentages of likelihood.

Wilhelm Reich’s (1949) theories of the dynamics of emotional change were described. Concepts of charge, discharge, and body armor were related to emotional homeostasis and the healing return of psychosomatic energy to be used in living life. Emotional well being was shown to be feeling free to choose one’s activities and having the resources to respond to each new moment and its unique experience.

The questions: “What is emotional illness?” “How do people get such an illness and how do they get better?” and “What does emotional health look like?” were addressed in relation to the model. The model was linked to a number of basic assumptions of transpersonal theory, and examples of two clients’ transformations
with therapy using the model were described. Use of the model for an educational, clinical training purpose was also described.

This model is offered as a tool for therapists and counselor trainers who want to show clients or students a diagram to illustrate many of the dynamics involved in emotional illness and restoration to health. It provides a map of the psychological territory related to emotional illness, healing, and health, integrating much of what we know about the emotional system into a single diagram. It reframes mental experience into a natural, ongoing flow of changing emotional states that sometimes needs recharging or recalibrating. It offers possibilities for integrating Eastern and Western psychotherapeutic interventions and suggests several new ways of conceptualizing and researching emotional concerns. The model provides multiple new opportunities for research related to emotions and how they work.

References


A Transpersonal Model


The Author

Carla Clements is an Associate Professor and the current chair of the Transpersonal Counseling Psychology Department at Naropa University in Boulder, Colorado. She teaches Transpersonal Psychology, Assessment, Group Dynamics and Helping Relationships in the Mindfulness-based Transpersonal Counseling program and Transpersonal Psychology in the on-line masters in ecopsychology program. She has been practicing psychotherapy in the Denver Boulder area for many years, specializing in the treatment of PTSD in women. Currently she is also the Independent Rater for the MAPS sponsored research on psychotherapy assisted MDMA treatment for chronic, treatment-resistant PTSD in Boulder CO.