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Struggles Reported Integrating Intense Spiritual Experiences: Results From a Survey Using the Integration of Spiritually Transformative Experiences Inventory

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In the aftermath of spiritually transformative experiences (STEs—such as mystical experiences, near-death experiences, religious conversions, and kundalini awakenings), experiencers (STErs) have sometimes reported prolonged challenging integration processes. To date, there have not been any empirical studies of practices and approaches to addressing these struggles. The purpose of this study was to assess the extent to which practices STErs themselves utilized and found helpful. The Integration of Spiritually Transformative Experiences Inventory was created based on recommendations of 84 helpful practices proposed by four experienced clinicians. The 431 respondents were recruited through online STE networks and social media. Of those, 245 met criteria for integration as assessed by the 5-item Mental Health Inventory, and transformation as assessed by the Posttraumatic Growth Inventory-Short Form. Participants rated 80 of the 84 practices as helpful. Twelve practices were rated by all participants as essential (4.0 on a Likert scale of 1–4) including (a) practicing compassion, forgiveness, gratitude, and self-awareness; (b) exploring the unconscious; (c) finding serene environments; and (d) reading spiritual literature, praying, and sharing with another person. A key finding was that across a variety of STEs, there were high levels of agreement regarding the integration practices rated as helpful, and that psychiatric care and medication were usually not reported to be helpful ($p < .001$). The correlation between helpfulness and frequency of use showed that STErs gravitated intuitively to what was the most useful for them ($p < .0001$). Findings offer guidance for STErs themselves and the health care providers who serve them.

Keywords: spiritual, transformative, integration, spiritual experience, spiritual transformation

A spiritually transformative experience (STE) is a term used to describe a variety of phenomena that have in common aspects of spiritual relevance and personal change. Many terms have been used to describe this type of experience such as religious experience (James, 1902/1958), peak experience (Maslow, 1964), exceptional human experience (White, 1999), quantum change (Miller & C'de Baca, 2001), and anomalous experience (Cardeña, Lynn, & Krippner, 2007). Kason (1994/2008) coined the term "spiritually transformative experience" to include these and others that had been studied over the previous decades, such as mystical experiences, conversion experiences, near-death experiences, and kundalini episodes. Although there is only limited discussion or acknowledgment of this process within the scientific literature, undergoing such transitions has been considered a prerequisite for various types of spiritual transformation, such as religious conversion (Mahoney & Pargament, 2004), spiritual awakening (Torbert, 2017), and shamanic initiation (Lukoff, 2007).

Both the religious literature and empirical research support the occurrence of the transformative effects of mystical experiences. Within the Christian tradition, historical and current literature addresses this phenomenon (*Cloud of Unknowing*; Butcher, 2009; Jung, 1965; Mahoney & Pargament, 2004; Underhill, 1911/2005). Within Islam, much of the mystical literature is found in the Sufi tradition (Bintari, 2015; Chittick, 2008; Schimmel, 1975; Sells & Ernst, 1996). In Judaism, the Kabbalah, particularly significant in Hasidism, carries the mystical strain of the religious teachings (Jacobs, 1977; Lazar & Kravetz, 2005; Scholem, 1995). Other examples of mystical traditions within major religions are kundalini yoga within Hindu (Harrigan, 2004; Krishna, 1997) and Zen/Tibetan practice within Buddhism (Chen, Hood, Yang, & Watson, 2011; Suzuki, 2006).

Successive Gallup polls over the last half-century have found that an increasing number of Western English-speaking people have experienced nonordinary spiritual experiences. In 1962, they found that 20% of respondents reported having experienced a religious or mystical experience or a moment of sudden religious insight or awakening. In polls taken between 1976 and 1988 the percentage ranged from 30% to 34%. A poll in 2002 showed 41% of respondents reporting a profound religious experience or awakening that changed the direction of their lives (Gallup, 2012). The

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Religious Experience Research Unit at Oxford University in England (Hay, 2006) reported that in 1987, 48% of British citizens claimed they had a spiritual experience, and in a 2000 follow-up survey 60% of the population reported having had a spiritual experience.

A principal problematic issue for spiritually transformative experiencers (STErs), in particular, is self-disclosure (Kason, 1994/2008; Palmer, 1999; Paper, 2004; Rominger, 2004). In modern American and Eurocentric society where the cultural sense of reality is guided by materialistic paradigms, people who unexpectedly experience an STE may have no reference with which to frame their experience. Thus, they may not be able to communicate what has happened; may fear that others will consider them insane; or may find themselves considered blasphemous, heretical, or even possessed (Bentall, 2007; Berenbaum, Kerns, & Raghavan, 2007; Paper, 2004; Wulff, 2007).

Researchers have consistently found no relationship between STEs themselves and mental disorder (Cardeña et al., 2007; Greyson, 2007; Noble, 1987; Streit-Horn, 2011). This is an important fact and points to the potential of iatrogenic diagnoses of mental disorders where they do not exist during STEs and during the following processes of integration. Mental disorders are regressive and tend to call for remedial interventions but STEs are progressive and tend to call for supportive and facilitative interventions (Cardeña et al., 2007; Holden, Greyson, & James, 2009; Torbert, 2017).

Although there may be some overlap in their presentation, there are also distinct differences between a psychiatric disorder and a mystical experience. Even when a mystical experience triggers a psycho-spiritual crisis, the person will typically emerge with both a higher level of daily functioning and improved mental health and well-being compared with prior levels before the experience (Grof & Grof, 1989; Harris, Rock, & Clark, 2015; Lukoff, 1985; Ring & Rosing, 1990). Recent studies have indicated that mystical and STEs are not only nonpathological, but also potentially beneficial (Gruel, 2017; Herrick, 2008; Mitchell, 2018; Racine, 2014).

One of the gravest risks is misdiagnosis of a psychotic disorder due to experiencers' reports of hearing and/or seeing things neither visible nor audible to others (Boisen, 1936/1952; Greyson, 2007). A primary challenge after experiencing an STE is for the person to readjust to the circumstances of his or her former life before the experience, and then to integrate the newly discovered insights and sensory information into their ongoing lives. Taking STErs out of their normal life to place them in an institution and/or prescribe psychotropic drugs can prolong this process and/or usurp the self-confidence needed to psychologically process the event (Lukoff, Lu, & Yang, 2011; Silverman, 1967; Torbert, 2017).

Most accepted knowledge in this field has been contributed by clinicians sharing their personal and professional experience. With a few exceptions in a few specific areas such as phenomenology of anomalous experiences and near-death experiences (Cardeña et al., 2007; Greyson, 1983; Greyson & Ring, 2004; Holden, 2012; Holden, Long, & McLurg, 2009; Hood, 1975; Radin, 1997; Ring & Rosing, 1990; Stout, Jacquin, & Atwater, 2006; Streit-Horn, 2011; Tart, 2009), most research has been qualitative, and has not addressed either STEs as an umbrella for a variety of triggers of transformation, and none have been quantitative studies that inquired into beneficial practices for integration. The present need for quantitative evidenced-based findings specifically addressing answers to the struggles of integration has been the impetus for this research study. There is a need for research to assist people coping with spiritual struggles:

> While digging more deeply into conceptual questions about [spiritual] struggles and their resolution . . . social scientists should try to glean from the wisdom of others who wrestle with these issues on a regular basis: theologians, philosophers, clergy, educators, pastoral counselors, chaplains, and spiritual directors, to name a few. (Exline, 2013, p. 469)

To address this need, the author conducted an extensive survey of the experiencers themselves to assess the prevalence of use and the usefulness of guidelines proposed by four experienced clinicians.

Definition of STE

To create an operational definition three distinct criteria were utilized addressing the three specific components of the term, that is, spiritual, transformative, and experience. The first criterion was that the experience must be a discrete spontaneous experience of an altered state of consciousness. Altered states of consciousness, often referred to as mystical, can include rapture, ecstasy, heightened sense of profundity, experiences of divinity, and ultimacy (Cardeña et al., 2007; Radin, 1997; Ritchey, 2003; Tart, 1969/1990). Ultimacy can be defined as sensing reality as more real than materially limited perception (Lomax, Kripal, & Pargament, 2011).

The second criterion in defining an STE was that the transformation must be profound in the life expression of the experiencer. A profound transformation is one that it is not merely a change in appearance or condition but rather an alteration in disposition, character, and nature of the person, evidenced by a seemingly permanent change in attitudes, beliefs, and/or behaviors (Bray, 2010; Holden, 2012; Mahoney & Pargament, 2004; Mainguy, Valenti Pickren, & Mehl-Madrona, 2013; Miller, 2004). It has been well documented that altered states of consciousness sometimes do not produce life-changing effects (Cohen, Gruber, & Keltner, 2010; Greyson & Ring, 2004; Holden, Long, et al., 2009; Mainguy et al., 2013). For the purposes of this study, only altered states leading to profound transformation in character and behavior qualified for this study.

The third criterion in defining an STE was that the transformation must be spiritual and involve the spiritual identity and behavior of the experiencer. Two aspects of spiritual needed be addressed for this study. First spiritual needed to be differentiated from religious. This distinction was taken from the *APA Handbook on Psychology, Religion, and Spirituality*, which suggests that spiritual "focus[es] on people's relationships with God or with a transcendent or sacred realm," whereas religious "center[s] upon teachings, practices, or group dynamics of an organized religious group" (Exline, 2013, p. 458).

A second aspect of spirituality is identity and behavioral transformation: was one's individual character, as a result of the STE, transformed to change one's personal values to focus beyond preserving one's own survival and gratifying one's own desires? Did the resulting behaviors show greater compassion, generosity, service to humanity, and expanded eco- and global perspectives?

In summary, the following operational definition of an STE was used: (a) a discrete spontaneous experience of an altered state of consciousness (b) that brings about a profound transformation in the (c) spiritual identity and behavioral life expression of the experiencer.

Spiritual Struggles of Integrating STEs

Researchers have tackled the question of why profound experiences sometimes result in spiritual transformation and sometimes do not. Boisen (1936/1952) held that the moral and ethical power of a person was the determining factor. Cohen et al. (2010) attributed outcome to the discrepancy in intensity of emotionality of the experience. Holden (2012) theorized three factors: the nature and emotional power of the experience itself, the developmental level and disposition of the individual, and the individual's social context that either supports or thwarts transformative potential and urges.

Periods of struggling with psycho-spiritual integration following an STE can last months, years, and even decades (Brook, 2018). Rominger (2014) proposed a seven-stage model for integration of STEs: (a) initial shock, confusion, and upheaval; (b) initial reorientation to worldly functioning; (c) internal identity and social referencing; (d) finding "new" internal and social identity; (e) asserting new self and losing old personal and social identity; (f) establishing homeostasis with new world view; and (g) engaging in the ever-changing process of continual growth.

The importance of discernment between spiritual experience and pathology during the phase of integration of STEs is that the experiencer is in a vulnerable state of disintegration of personality structures that may mimic various mental disorders. The very nature of the spiritual struggles of this inner change leaves an individual susceptible to a sense of insecurity and confusion. Integration of STEs involves changes in mental, emotional, and sometimes physical structures that are presumably in place in a person's identity before their STE, yet must expand and alter so radically during the period of transformation that the challenge of the change creates disturbance in the person's life. To undergo this kind of change in the psyche involves a period of unraveling, losing control of parts of one's sense of reality and thus of one's sense of one's own identity.

Spiritual struggles associated with integration of powerful experiences has been compared with posttraumatic growth (PTG; Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996), and STEs in particular (Greyson, 2007). Tedeschi and Calhoun (1996) theorized that survivors of posttraumatic stress disorder may not only recover their former level of functioning but may improve over preevent functioning during the posttraumatic period of integration. Calhoun and Tedeschi (2006) found evidence of "transformation or reformulation" (p. 11) of the person's character and personality resulting from the period of time wrestling with the challenges of integrating a traumatic experience. Calhoun and Tedeschi (2006) put forth a theory that reformulation involves a specific inner process they refer to as rumination:

> This ruminative process involve[s] establishing "comprehensibility" first. This is the attempt by survivors to grasp that what has happened really *has* happened. When fundamental understandings of personal reality are violated there seems to be a time lag between the event and a full appreciation that circumstances are irrevocably changed . . . [following this] comes a better chance at manageability, figuring out ways to cope with the changed circumstance, and reaching the conclusion that one has the resources to deal with it . . . A final piece of the engagement is "meaningfulness," and this is the more reflective element that can yield PTG. (p. 10)

The Integration of Spiritually Transformative Experiences Inventory (ISTEI) research study utilized clinicians' recommendations of what the process of psycho-spiritual integration entails combined with PTG research, clinicians' pooled knowledge, and direct response from individuals who have successfully struggled through the process of integrating their STEs (Brook, 2018). In conclusion, the data from the ISTEI study furnished an evidence-based platform from which to begin to understand and help people going through these challenges.

Method

This research study received approval from the Research Ethics Committee at Sofia University.

Development of the ISTEI

The research question in this study was: what practices, habits, and behaviors assist an individual to integrate a transformative spiritual experience (STE)? The purpose of the research study was to assess the validity of suggested guidelines put forth by four leaders in the field of integration of STEs: (a) Lukoff (Lukoff et al., 2011) suggested nine therapeutic interventions for spiritual and religious problems that are helpful to people in integrating spiritually transformational experiences, (b) Rominger (personal communication, November 4, 2014) outlined four pivotal situations that determine the degree of difficulty or ease in integrating an STE, (c) Stout (Stout et al., 2006) identified six significant areas of challenge for people during the process of integrating STEs, and (d) Kason (1994/2008) listed practices and habits to help a person survive the process of integration of STEs.

The ISTEI was created for the survey by operationalizing guidelines from the four experts into 84 distinct practices, habits, and behaviors. The items were then converted to statements adapted for rating on the following Likert scale:

0. I didn't try this practice.
1. This practice was **not at all** helpful for integrating my STE.
2. This practice was **somewhat** helpful for integrating my STE.
3. This practice was **very** helpful for integrating my STE.
4. This practice was **essential** for integrating my STE.
5. I **wish I had the opportunity** to have tried this. It would have been very helpful.

This Likert scale allowed data collection for two separate measurements. (a) Frequency of use was determined by counting Answers 0 and 5 as the practice was not used, and Answers 1–4 as the practice was used. (b) Rating of helpfulness based on the

responses of those who reported using the practice on the scale of 1–4, corresponding with the descriptions *not at all helpful, somewhat helpful, very helpful*, and *essential*.

Recruitment of Participants

Because the survey was to be distributed online through SurveyMonkey, and because the survey took an extended amount of time (30 to 60 min), it was designed to be as user friendly as possible. There were no restrictions put upon the respondents except that multiple submissions from the same IP were not permitted (by the SurveyMonkey program). There was no time limit for taking the survey, many questions allowed multiple answers, questions were allowed to go unanswered, and there was no requirement to finish the survey. Only the data from participants who finished at least the two screening psychological tests were used in the study. No use of adjunct software to record and later reconstruct paradata such as timing, scrolling, and clicking was employed.

The survey was designed to strongly appeal to participants to encourage them to finish despite the long length of the survey and the intimate questions asked. It was designed to be beneficial to the participants. The questions in themselves offered informative and potentially helpful suggestions from authorities in clinical fields that support STE integration. Intimate material was elicited, so care was taken to phrase questions in a respectful manner and opportunity at the end was given for participants to tell their story in a text box. Intention of methodology was to make the survey experience valuable enough, with few enough frustrations, to encourage participants to finish the survey, because no compensation was offered for finishing. The survey instrument was piloted through testing with several experts in the field of psychological/spiritual integration of STEs.

Recruitment began with reaching out through personal connections and emails to STE support and research networks and other religious and educational institutions, including online social media resources such as Facebook. Participants responded to the invitation to take the online survey through SurveyMonkey if they had a profound life-changing spiritual experience that took months to years to integrate into their lives. For the purpose of recruitment, STE was defined as "a discrete spontaneous experience of an altered state of consciousness that brought about a profound transformation in your spiritual identity and life expression." People, regardless of sex, race/ethnicity, nationality, socioeconomic status, educational status, or religious/spiritual preference, were eligible. Participants were required (by self-report) to be at least 18 to provide legal informed consent (Figure 1).

Additional Instruments

Two standardized instruments included in the survey were chosen to select from the full number of respondents only those who met criteria for the study. Selection criteria were: (a) respondents who had sufficiently integrated their STE. Although no requirement was made for taking the survey (which allowed individuals who were still in crisis or in some state of spiritual emergency to gain the benefits of exposure to the ISTEI), only those deemed sufficiently mentally stable, socially adjusted, and sufficiently recovered from psycho-spiritual challenges of STE integration were used for data collection. (b) Respondents were selected who showed evidence of having undergone an STE that was sufficiently challenging and took extended time to integrate into their lives. These criteria were introduced in the recruitment letter, which called for "people who have had a profound life-changing spiritual experience that took months to years to integrate into their lives."

For further validation of selection criteria, utilization of standardized instruments were chosen to further screen the respondents. Instruments chosen for confirming level of integration and authenticity of transformation were, respectively (a) short forms of the Mental Health Inventory (MHI-5; Berwick et al., 1991) and (b)

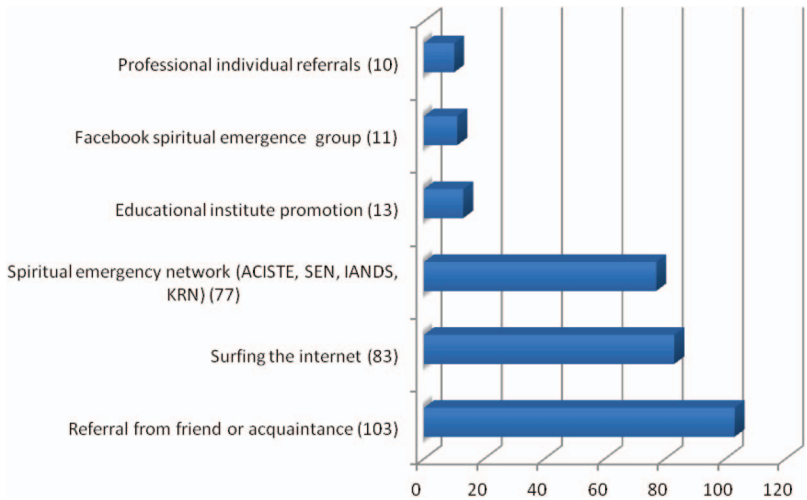

Figure 1. Self-reported sources of recruitment by percentages and numbers of participants. ACISTE = American Center for the Integration of Spiritually Transformative Experiences; SEN = Spiritual Emergence Network; IANDS = International Association for Near-Death Studies; KRN = Kundalini Research Network. See the online article for the color version of this figure.

Posttraumatic Growth Inventory-Short Form (PTGI-SF; Cann et al., 2010).

To confirm that the participant had sufficiently integrated their STE, the MHI-5 was used. The original MHI (Veit & Ware, 1983) was a 38-question test measuring psychological distress and well-being. It was designed with a factor model composed of a general underlying psychological distress versus well-being factor; a higher order structure defined by two correlated factors—Psychological Distress and Well-Being; and five correlated lower order factors—Anxiety, Depression, Emotional Ties, General Positive Affect, and Loss of Behavioral Emotional Control. Summated rating scales produced high internal consistency estimates with Cronbach's alpha of .90 (Veit & Ware, 1983). A shortened form of the scale, the MHI-5 (Berwick et al., 1991; Rumpf, Meyer, Hapke, & John, 2001) was used in this study. This five-item version of the MHI was tested and shown to be as good in detecting depressive, anxiety, and general affective disorders as the MHI (Berwick et al., 1991). Subsequent reliability assessment of the MHI-5 yielded Cronbach's alphas of .84 (McCabe, Thomas, Brazier, & Coleman, 1996), and .8 (Strand, Dalgard, Tambs, & Rognerud, 2003). The MHI-5 was used by the National Institutes of Health in the United States for use in screening for mood disorders (Rumpf et al., 2001), by the Norwegian Institute of Public Health for use in surveying general health as well as mental health (Strand et al., 2003), and by the Australian Government Department of Health (2017) for use as a global mental health index. The recommended cutoff point of 65 (Kelly, Dunstan, Lloyd, & Fone, 2008; Rumpf et al., 2001) was used to determine if a respondent met inclusion criteria for well-being with absence of mood disorder. For the STE study, it was presumed that if a test score indicated a sufficient level of well-being and absence of pathological levels of anxiety or depression, then the participant had the capacity to function in the workplace, in personal relationships, and in social situations.

For the purpose of confirming that the STE survey respondent had experienced a life-transforming event, and to furnish a cut-point for whether a person had reached a sufficient level of psycho-spiritual integration, the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) was chosen for its wide range of use and because a short form (PTGI-SF) with 10 questions was available (Cann et al., 2010).

The 10-question PTGI-SF (Cann et al., 2010), like the original 21-question PTGI (Tedeschi & Calhoun, 1996), measured the experience of positive change resulting from struggle with highly challenging life circumstances. The five subscales of these psycho-spiritual changes were: Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life. Internal reliability reported by Cann et al. (2010) was Cronbach's alpha of .90. The only adaptation needed for use of the PTGI-SF was the substitution of the term "STE" for "crisis" in the six Likert scale responses. The recommended score of 30 (out of 50 possible points) was chosen as the cutpoint for the purpose within this study.

Data Analysis

Data were analyzed for frequency of use of the practices by using binomial data. First, a dichotomous (yes/no) variable was constructed by recoding the responses (i.e., "didn't try this practice," and "I wish I had the opportunity to try this") as *no*, and indicating the other four responses (i.e., *not at all helpful; somewhat helpful; very helpful; essential*) as *yes*. Percentages of yes responses for each ISTEI item were calculated, with higher percentages indicating greater usage of the item. The overall usage of each practice was calculated. Based on these percentages, practices were rank-ordered from most frequently used to least frequently used.

To calculate mean reported helpfulness for each practice, only the responses of those who said yes in the dichotomous analyses were used. Therefore, n ranged between 1 and 4. For each item for which at least two respondents reported using the practice, the mean degree of reported helpfulness was calculated, along with a standard deviation of reported helpfulness, and a 95% confidence interval (CI) around the mean. Based on these means of rated helpfulness, practices were rank-ordered from most helpful to least helpful.

Employing the approach of exploratory data analysis, a scatterplot of ranked mean rated helpfulness (y-axis) by ranked percentage of frequency of use (x-axis) was used to determine correlation between the two. The Spearman's correlation test, chosen because of the abnormal distribution of the data, measured the overall relationship between each practice's comparative (rank ordered) helpfulness and its comparative (rank ordered) prevalence of use. Spearman's correlation coefficient was chosen over Kendall's tau because there were few ties, the sample size was large, and the practices' mean helpfulness and prevalence of use were both continuous variables.

In order to begin to examine potential patterns, the 84 practices were divided into the original eight groups chosen to organize the survey in a user-friendly manner. All of the practices ranking lowest in helpfulness appeared in Group 6. Group 6 divided itself naturally into two groups (Groups 6A [alternative health professionals] and 6P [psychiatry and medications]); thus, nine groups resulted. Five items were reverse-scored across all the groups to make them match the Likert scale measurement more accurately. With these resulting nine groups, differences were charted using a negative binomial model. This comparison was graphed with a box plot.

The next primary pattern that stood out was that three layers of ratings were easily separable. Most participants used the practices rated essential to very helpful (66% of practices). The least helpful practices consisted of four items (5% of practices). A middle layer of 24 items (29% of practices) existed between the two, which, on average, were rated between somewhat and very helpful.

Results

Inclusion Criteria

Meeting the cutpoints for the MHI-5 suggested that the respondents' mental health status was stable; thus they most likely had integrated their STE. Passing the PTGI-SF suggested that their experience was a spiritually transformative event that profoundly and permanently changed their lives. Together these two tests furnished inclusionary criteria to utilize the participants' opinions about which practices had been helpful in their integration process (Figure 2).

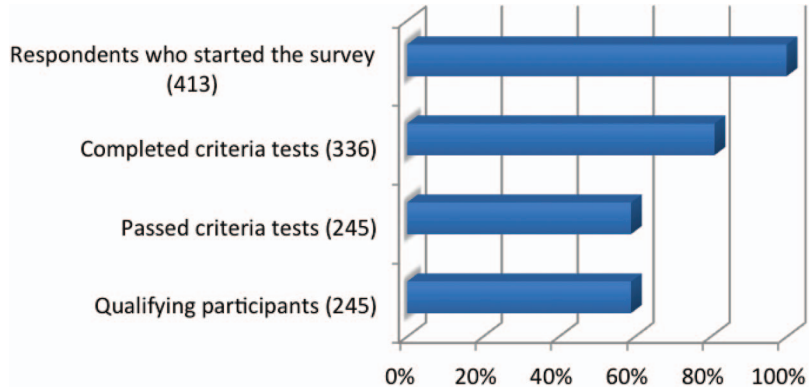

Figure 2. Results of criteria testing to determine whether participants' data qualified for the Integration of Spiritually Transformative Experiences Inventory study shown as percentage of respondents who began filling out the survey. See the online article for the color version of this figure.

Demographics

Ages of participants meeting the criteria varied broadly between 18 and over 75 years old, with median age between 45 and 54. Of the 245 participants, 177 were female and 68 were male. White participants made up 88% of the sample, with representation from all major races and nationalities. Participants claimed nationality from 33 different countries on six continents. Slightly more than half of the participants were from the United States, 14% from United Kingdom, and 6% from Canada. The most represented non-English speaking country was Romania where 6% of participants reported nationality. Household income varied widely, with the most frequently reported $0-$24,999 annual income at 31%. Occupations, which were not limited to one per person, averaged 1.54 per participant. Helping professions were the most commonly reported (66%), followed by education (33%), business (30%), arts (21%), and trades (4%). Religions, also not limited to one per person, averaged 2.02 per participant. All major religions were represented. Forty-five percent of participants chose "no religion." Fifty-one percent chose some form of Christian religion, and 37% chose "interdenominational" and/or "other."

Characteristics of STEs

Participants reported their age at the time of their STE. Age at time of STE ranged from childhood to old age, with median age at time of experiencing STE reported to be 25–34 years old. Participants' reports of how many years ago they experienced their STE was evenly distributed between less than a year and over 30 years ago. Given choices ranging from seconds to weeks, the most commonly reported duration of the STE was weeks (34% of participants) and minutes (22%).

Participants reported how long adjustment took (function comfortably and well in society, such as viable employment, stable family relationships, sufficient social support, and good health) and how long psycho-spiritual integration took (comfortable with your personal identity and your direction in life, such as at peace with inner changes, stabilized in your spiritual orientation, comfortable with habits of physical, mental and social balance, sensing harmony between your inner identity and outer activities). Choices ranged from days to decades, with an additional category, "have not yet adjusted/integrated." The most frequent time of adjustment reported was days (72 responses, 29%) and the most frequent time of integration reported was years (92 responses, 38%). The overall comparison showed that generally an STEr takes longer to psycho-spiritually integrate their STE than for them to adjust societally (Figure 3).

Of note is the "not fully integrated/adjusted" selections. Those who reported having not yet fully adjusted and/or integrated correlated significantly ($p < .001$) in chi-squared tests both with each other and with those who did not meet the MHI-5 cutpoint that was used as criterion to select participants who had sufficiently integrated their STE (Brook, 2018).

Descriptions of the STE, which were not limited to one per person, averaged 3.5 per participant. The most frequently used descriptions were mystical experience (63%), unitive experience (i.e., of being one with the universe; 52%), and energetic experience within the body (44%; Figure 4).

Findings

Regarding frequency of use, all of the practices were used by at least some of the participants. Half of the participants (50%) used at least 63% of the practices. Across all practices, average use by participants was 62%. The practices least used were used 18% of the time (Table 1).

Regarding reported helpfulness, all of the practices were considered helpful by at least some of the participants. Most of the practices (90%) that were considered very helpful ranked 3–3.9 (76%) or essential ranked 4.0 (14%; Table 2).

The two lists of ranked orders for mean helpfulness and percentage were compared. This relationship is shown as a scatterplot in Figure 5.

To better examine this relationship, values of mean-rated helpfulness and percentage of use were replaced by ranks. Spearman's correlation coefficient of .788 showed significant correlation ($p < .0001$) between the usage and the helpfulness of the practices. The significance of this strong statistical correspondence indicates that, on average, the practices rated most helpful were also used more frequently, whereas those rated least helpful were used less frequently (Figure 6).

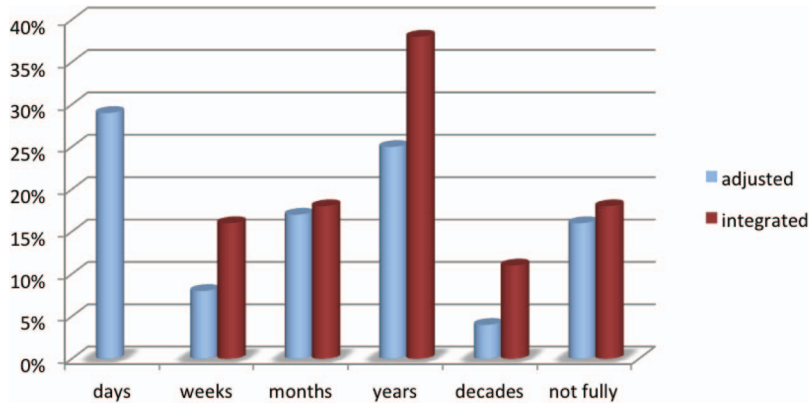

Figure 3. Self-reported length of time for societal adjustment to and psycho-spiritual integration of spiritually transformative experiences. See the online article for the color version of this figure.

Thematic Groups Compared

To compare ratings of helpfulness of the 84 items with each other, the responses were divided into the same eight thematic groups chosen in creating the ISTEI, and five items stated in negative form were reverse-scored. The range of ratings in Group 6 (seeking professional clinical help) was noticeably greater than in any other group, and contained the lowest ratings overall in the inventory responses. Upon greater inspection, Group 6 was easily divisible into two distinct groups. One group was utilizing psychiatric professionals practicing within conventional medicine. The other group was utilizing alternative heath and healing therapeutic modalities (psychotherapy, massage, bodywork, and other nonallopathic practices that may prescribe herbs, homeopathic treatment, supplements, etc.). For clarity and consistency, Group 6 was separated into two groups, Group 6A (alternative health professionals) and Group 6P (psychiatry and medications; Table 3).

To further examine the statistical relationship of Group 6P to the other eight groups, the mean of participant ratings of all practices in the groups was calculated (Table 4).

Differences of mean helpfulness in each group were modeled using a negative binomial model. Group 6P had a significantly lower mean helpfulness compared with each of the other nine thematic groups ($p < .001$). The mean helpfulness of Group 6P was 1.82, and 95% CI [1.56, 2.08]. A negative binomial model was used to model the discrete data for the mean helpfulness score because the scores were based on a Likert scale metric and therefore not continuously distributed. The estimates of the negative binomial model were adjusted for multiplicity using a Tukey's adjustment in order to keep the overall alpha level of .05. Because ratings were based on the Likert scale, which is not a bell-curve-shaped normal distribution, scale counts of 1 through 4 were used to correspond to the Likert scale (Figure 7).

This strong pattern is best recognized when the practices were grouped thematically with their mean rates of helpfulness statistically analyzed with pairwise comparisons. Items in Group 6P (psychiatric care and taking medication) showed significant difference of $p < .001$ between it and each of the other eight groups in pairwise comparisons. The eight groups rating very helpful

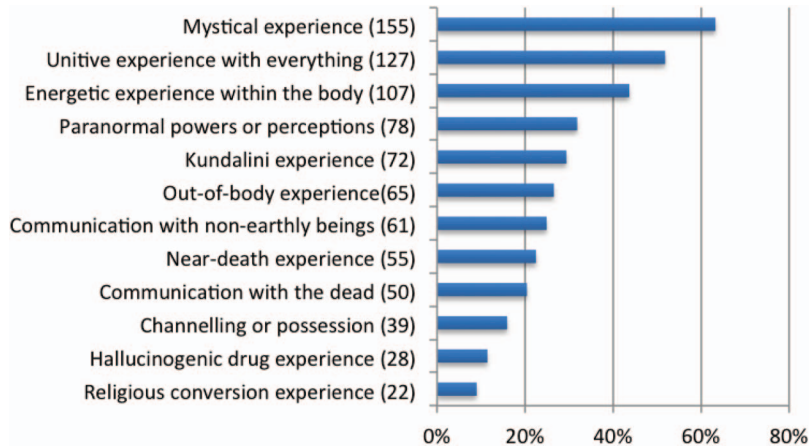

Figure 4. Descriptions of spiritually transformative experiences. See the online article for the color version of this figure.

Table 1
Percentage of Use of Each Practice Rank Ordered

Practice, habit, or behavior	Percentage used
I practiced compassion	97
I spent more serene time alone	96
I allowed my psychological and spiritual issues to surface rather than resisting them	96
I practiced honesty	95
I studied information about the nature of spiritual experience and spiritual transformation	94
I attended to serving others, even if in small ways	93
I chose the right people to share the experience with	93
I practiced gratitude	93
I spent more time in nature	93
I found assurance that others had experienced and were experiencing similar things	93
I shared with at least one friend who was interested, supportive, and helpful	91
I practiced forgiveness	90
I found ways to find and live a revised purpose more fulfilling for me	88
I found calmer environments	88
I found ways to verbally express what I had experienced	88
I practiced humility	87
I nurtured calmer interactions with people	86
I read holy books within my tradition and/or other spiritually uplifting books	86
I worked on getting in touch with my feelings	85
I found ways to minimize stress in my life	85
I worked on developing healthy relationships	85
I slowed down and minimized busyness	84
I found people to listen to my inner experiences in a nonjudgmental way	84
I found ways to adjust to more sensitivity to others' suffering	83
I found ways to match my new spiritual values with my earthly expectations and the expectation of others	82
I worked on getting in touch with my thought patterns	82
I found ways to adjust to increased awareness of inner sensations	81
I increased relaxation	80
I found ways to adjust to more awareness of other's thoughts and/or feelings	80
I found ways to radically shift my sense of reality after my STE	80
I practiced surrender to the divine	79
I found ways to express my inner experience though writing	78
I practiced daily meditation	78
I sensed that on some level I had chosen to create the radical change happening in my life	78
I found at least one reliable safe place to let down and authentically share what was happening with someone else	77
I found ways to adjust to more awareness of metaphysical events	76
I found people to validate my experiences and assure me that I was not psychotic	74
I practiced walking or other slight exercise in a pleasant environment	72
I shared with at least one family member who was interested, supportive, and helpful	71
I spent more time with relaxed people	71
I engaged with a supportive spiritual community	71
I found ways to have regular communication with my partner or a trusted friend	69
I found ways to accept returning from the expanded place of my STE back to the earthly realm	68
I spent more time in natural light	67
I practiced simple focused calming activities	67
I focused on remaining active in society	67
I increased rest	66
I worked on exploring my unconscious "dark side"	65
I found ways to adjust to more sensitivity to light, sound, smell, taste, or touch	59
I increased sleep	55
I minimized junk foods	54
I practiced daily prayer	54
I considered or sought help from alternative medical professionals and/or healers	52
I chose not to take prescription medicine for psychological balance	50
I found ways to endure the responses I got from some people I told about my STE	47
I found ways to express my inner experience through some other creative practice	46
I found ways to accept which part of my story interested other people (sometimes things not important to me intrigued them, or things important to me were overlooked or discounted by them)	45
I cut alcohol out of my diet	41
I increased self-massage and/or bathing and showering	41
I sought psychotherapy or counseling	39
I scheduled regular exercise	39
I practiced visualizing my energy field connecting to the center of the earth through the base of my spine and/or the soles of my feet	37

(*table continues*)

Table 1 (*continued*)

Practice, habit, or behavior	Percentage used
I increased light manual work such as gardening or housekeeping	36
I found ways to adjust to more sensitivity to toxic chemicals	36
I spent less time concentrating or reading	35
I discontinued recreational drugs	35
I found ways to adjust to more ability to predict the future	35
I found ways to adjust to more sensitivity to electromagnetic fields	32
I ate heavier foods such as meats, proteins, and/or carbohydrates	30
I considered or sought psychiatric help	30
I scheduled regular sleep cycles	29
I scheduled regular meals	28
I increased receiving massages	28
I considered taking prescription medicine for psychological balance	28
I avoided fasting	25
I found ways to express my inner experience though movement	25
I worked at a workplace that offered support and encouragement	23
I cut sugar out of my diet	22
I practiced visualizing my energy field withdrawing to my center and/or dropping from my head to lower body	22
I lessened the rigor of my spiritual practice(s) of yoga/meditation/chi kung	21
I found ways to express my inner experience through drawing or painting	20
I cut caffeine out of my diet	19
I chose to take prescription medicine for psychological balance	18
I moderated sexuality, to adjust to my fluctuating libido	18

Note. STE = spiritually transformative experience.

showed means of ratings between 2.9 and 3.4 (2.0 = *somewhat helpful*, 3.0 = *very helpful*). In contrast, the mean rating of Group 6P was 1.8. (1.0 = *not at all helpful*, 2.0 = *somewhat helpful*; Figure 8).

Of all 84 practices, 66% were reported to be essential to very helpful. There were several patterns within the middle range of reported helpfulness (2.2–3.6) that made up 29% of the practices. These middle category items have characteristic patterns of their own, when examined more closely, and one overall pattern which is commonality of being foreign to American and Western culture (Brook, 2018). Only psychiatric care and taking medication (totaling 5% of items) were reported to be somewhat helpful to not at all helpful.

Discussion

Comparative Studies

Guidelines for how to assist people in integrating STEs have been primarily anecdotal, proposed by experienced clinicians with sufficient STErs in their caseload to put forth suggestions based upon their clinical experience. Heretofore quantitative research such as this study in the field of integrating STEs has been lacking. One aspect of this research that stands on its own with no previous comparable studies is that this quantitative research addresses only and specifically methods of integration. Most of the previous research studies of various transformative events inquired into frequency, phenomenology, and postexperience changes. There is little, if any, research that directly addresses the experiencer's challenges and needs during their period of integration.

A characteristic unique to this research study is the inclusion of a broad range of STEs. The ISTEI study has furnished new information showing evidence of commonality of several different types of STEs, which previous to this study have not been analyzed together as a group, or even conclusively identified as a common group. Qualitative studies and a few quantitative studies (Greyson, 1993; Radin, 1997; Ring & Rosing, 1990; Tart, 2009; White, 1999) have addressed experiences of near-death, paranormal, kundalini, and spontaneous healing. These studies addressed only one type of transformative or nonordinary experience. One exception was Greyson and Ring's (2004) study comparing near-death experiences with kundalini awakenings and White's (1999) descriptive lists of a wide variety of paranormal experiences.

A recent project was launched in this area of inquiry also using the assumption that different types of STEs have sufficient aspects in common that they can be treated as a group. Over the past several years concurrent with, yet independent from, this ISTEI survey research study, a group of clinicians met to create a set of competencies. At the time that the ISTEI survey was posted online collecting responses, a new manual was being published entitled *Spiritual and Religious Competencies in Clinical Practice* (Vieten & Scammell, 2015). In Chapter 6 of this book, spiritual crises are addressed inclusively, which carries a concurrent assumption of viewing diverse STEs as a group. With the findings from this ISTEI survey, that assumption has been empirically validated. This is not to assert that differences such as types of STEs, age, culture, or other groupings would not involve different integration trajectories, but findings from this study give evidence that across STEs a the same practices were deemed helpful, often essential, and that the frequency of use corresponds to these ratings ($p < .0001$). This finding validates the original assumption that different STEs involve strong similarities in integration processes.

Significance of Results

The findings showed that all of the 84 items were used, with the least used items used 18% of the time. Over 50% of the items were used by over 50% of the participants, and 90% of the

Table 2
Averages of Helpfulness Ratings for Each Practice Rank Ordered

Practice, habit, or behavior	Average rating for helpfulness
I practiced compassion	4.00
I found calmer environments	4.00
I allowed my psychological and spiritual issues to surface rather than resisting them	4.00
I found ways to adjust to more awareness of metaphysical events	4.00
I found ways to express my inner experience through some other creative practice	4.00
I studied information about the nature of spiritual experience and spiritual transformation	3.98
I practiced forgiveness	3.98
I practiced humility	3.98
I found ways to find and live a revised purpose more fulfilling for me	3.98
I found ways to adjust to increased awareness of inner sensations	3.97
I practiced honesty	3.96
I practiced gratitude	3.95
I spent more serene time alone	3.94
I worked on getting in touch with my feelings	3.93
I spent more time in nature	3.93
I worked on getting in touch with my thought patterns	3.93
I found ways to minimize stress in my life	3.93
I spent more time with relaxed people	3.93
I found ways to radically shift my sense of reality after my STE	3.92
I found ways to express my inner experience through drawing or painting	3.91
I found ways to adjust to more sensitivity to others' suffering	3.91
I found at least one reliable safe place to let down and authentically share what was happening with someone else	3.90
I sensed that on some level I had chosen to create the radical change happening in my life	3.90
I nurtured calmer interactions with people	3.90
I practiced daily prayer	3.90
I chose the right people to share the experience with	3.89
I found ways to adjust to more sensitivity to light, sound, smell, taste, or touch	3.88
I practiced surrender to the divine	3.88
I found ways to match my new spiritual values with my earthly expectations and the expectation of others	3.88
I increased relaxation	3.86
I read holy books within my tradition and/or other spiritually uplifting books	3.85
I found ways to accept returning from the expanded place of my STE back to the earthly realm	3.85
I considered or sought help from alternative medical professionals and/or healers	3.85
I found people to listen to my inner experiences in a nonjudgmental way	3.85
I found ways to adjust to more awareness of other's thoughts and/or feelings	3.85
I found ways to express my inner experience though writing	3.84
I shared with at least one friend who was interested, supportive, and helpful	3.83
I practiced daily meditation	3.83
I minimized junk foods	3.82
I found ways to verbally express what I had experienced	3.82
I worked on exploring my unconscious "dark side"	3.82
I attended to serving others, even if in small ways	3.82
I found assurance that others had experienced and were experiencing similar things	3.82
I found ways to express my inner experience though movement	3.81
I worked on developing healthy relationships	3.80
I chose not to take prescription medicine for psychological balance	3.80
I practiced walking or other slight exercise in a pleasant environment	3.79
I slowed down and minimized busyness	3.78
I practiced simple focused calming activities	3.78
I found ways to adjust to more sensitivity to toxic chemicals	3.78
I discontinued recreational drugs	3.77
I spent more time in natural light	3.74
I found ways to have regular communication with my partner or a trusted friend	3.71
I found people to validate my experiences and assure me that I was not psychotic	3.71
I increased rest	3.70
I engaged with a supportive spiritual community	3.70
I increased receiving massages	3.69
I cut alcohol out of my diet	3.66
I increased self-massage and/or bathing and showering	3.62
I practiced visualizing my energy field connecting to the center of the earth through the base of my spine and/or the soles of my feet	3.59
I found ways to adjust to more sensitivity to electromagnetic fields	3.55
I practiced visualizing my energy field withdrawing to my center and/or dropping from my head to lower body	3.55
I increased sleep	3.54

(*table continues*)

Table 2 (*continued*)

Practice, habit, or behavior	Average rating for helpfulness
I scheduled regular exercise	3.53
I moderated sexuality, to adjust to my fluctuating libido	3.48
I scheduled regular sleep cycles	3.48
I cut sugar out of my diet	3.47
I scheduled regular meals	3.42
I found ways to adjust to more ability to predict the future	3.40
I found ways to endure the responses I got from some people I told about my STE	3.32
I increased light manual work such as gardening or housekeeping	3.23
I found ways to accept which part of my story interested other people (sometimes things not important to me intrigued them, or things important to me were overlooked or discounted by them)	3.21
I sought psychotherapy or counseling	3.19
I focused on remaining active in society	3.13
I cut caffeine out of my diet	2.88
I lessened the rigor of my spiritual practice(s) of yoga/meditation/chi kung, etc.	2.76
I shared with at least one family member who was interested, supportive, and helpful	2.74
I avoided fasting	2.71
I worked at a workplace that offered support and encouragement	2.55
I ate heavier foods such as meats, proteins, and/or carbohydrates	2.44
I spent less time concentrating or reading	2.24
I considered or sought psychiatric help	2.00
I considered taking prescription medicine for psychological balance	1.50
I chose to take prescription medicine for psychological balance	1.34

Note. STE = spiritually transformative experience.

items were rated between very helpful and essential. All of the practices were used by at least some of the participants. Half of the participants (50%) used at least 63% of the practices. Across all practices, average use by participants was 62%. The practice least used was used 18% of the time. Sixty-six of the 84 practices (66%) were rated between very helpful and essential, and four (5%) were rated as least to not at all helpful. This lowest group (psychiatry and medication) differed significantly from the rest of the items when all items were divided into nine thematic groups ($p < .001$). Significant ($p < .0001$) correspondence was shown to exist between the percentage of participants who used a practice with the mean rating of the helpfulness of the practice.

An important pattern in the analysis was that people who integrate STEs agree on essential and helpful practices, as well as what is not helpful, and that the pattern of correspondence between rated helpfulness and frequency of use is consistent. These strong patterns of correspondence suggest two important things. First, that there is a consistency of opinion among a large diversity of participants and experiences regarding what practices were helpful in integrating an STE. Second, they suggest that individuals in the

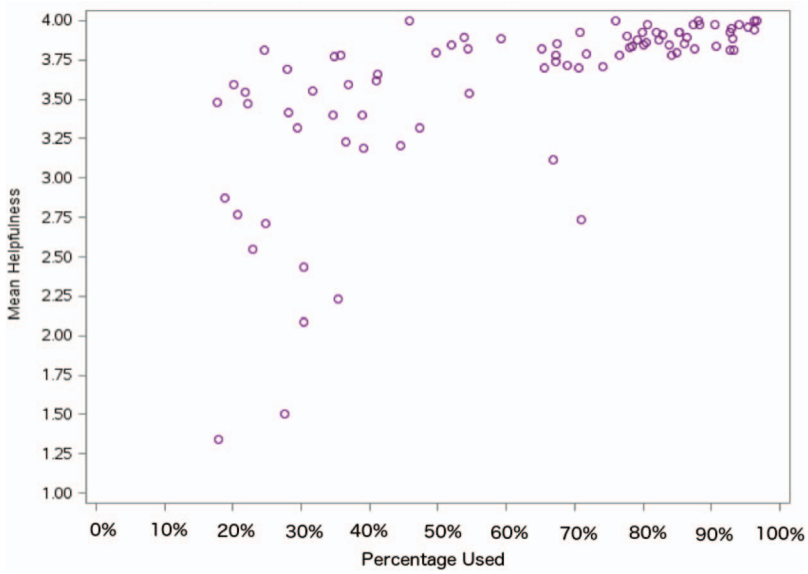

Figure 5. Scatterplot of percentage of use and mean rated helpfulness. See the online article for the color version of this figure.

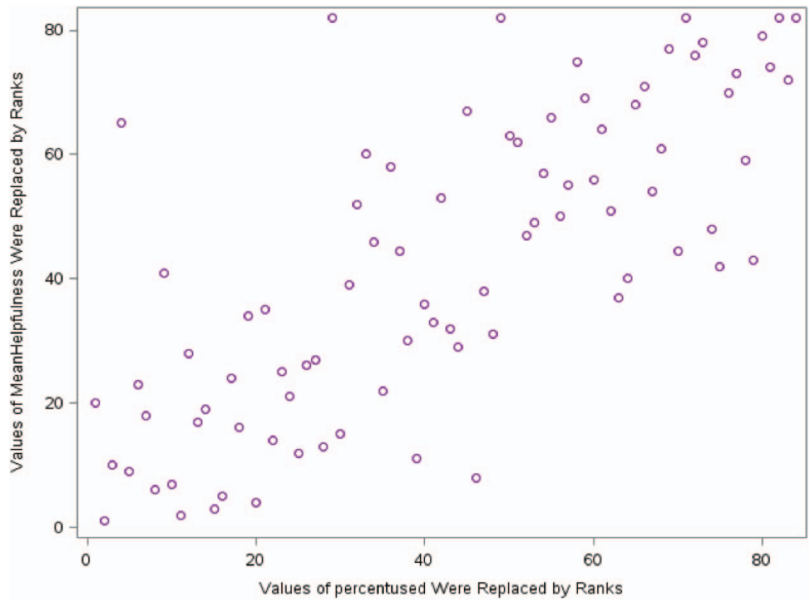

Figure 6. Spearman's rating of .788 ($p < .0001$) showing strong correlation between values of mean rated helpfulness and percentage of use by ranks. See the online article for the color version of this figure.

process of integrating STEs naturally and intuitively seek out, on their own, practices, habits, and behaviors that are the most beneficial, given that there is little formal clinical or public guidance for this process.

Notable in the findings were that (a) 96% (highest percentage of people trying any single practice) of participants practiced compassion, found calmer serene environments, and allowed their psychological and spiritual issues to surface rather than resisting them. Of these participants, 100% rated these three practices as essential (highest rating of helpfulness) for integrating their STE, and (b) on the other end of the spectrum, the practices considered least helpful or not helpful (lowest rating of helpfulness) were seeking psychiatric help and taking prescription medication. Of the participants, 28% sought psychiatric help and 18% (lowest percentage of participants trying any single practice) took psychiatric medications.

Psychiatric care and taking medication (Group 6P) contained the only practices reported, on average, to be not helpful. Of equal importance was that the item reverse-scored, "I choose to not take prescription medicine for psychological balance," was rated essential (3.8) by 50% of the participants.

This finding from the ISTEI survey is particularly important because of the prevalence of misdiagnosis within spiritual crisis situations. Individuals undergoing the psycho-spiritual transformative processes that follow STEs can exhibit symptoms that mimic psychosis. The difficulties that individuals encounter while integrating STEs can be seriously exacerbated when psychiatric misdiagnosis occurs and/or when inappropriate psychiatric medications are prescribed.

Strengths of Study

The diversity of participants and of their experiences was one strength of the study. With the power of the Internet, all six continents were represented, all major races represented, a balanced spread of ages from 18 to older than 75, all economic strata, and all major religions were represented. Diversity was also a strength when considering the range of STEs. Over half of the participants reported a mystical experience and/or a unitive divine experience, and near-death experience, religious conversion experience, kundalini experience, hallucinogenic drug experience, and communication with beings on other realms of reality were all strongly represented. Duration of the STE, length of time having passed since the STE, and length of time to adjust and to integrate the STE ranged widely.

Correlational analysis indicated that the tests served for the purpose they were used, which was to select the respondents for the study sample who had integrated their STE sufficiently. The comparable responses to survey questions regarding description, duration, and length of time of adjustment and integration of STEs among participants who met the cutpoint for the PTGI-SF matched expectation of the type of STEs this study was interested in examining, verifying that those who met the cutpoint for the PTGI met criteria. There was statistically significant correspondence ($p < .001$) between respondents who chose the answer "I have not yet integrated my STE" with the same respondents who did not meet the cutpoint of the MHI-5 test.

Limitations and Delimitations

This was not a representative sample, because it was not possible to locate a large group of people who have experienced STEs and then to take a sample from that group. Instead, this exploratory study consisted of recruiting through attraction in order to find the largest number of qualified participants possible.

A delimitation in the ISTEI instrument was that except for the correlation between self-reported integration and adjustment, on the one hand, and mental health scores, on the other hand, the

Table 3
Practices Divided Into Thematic Groups

Thematic group	Practices, habits, and behaviors	Helpfulness rating
1. Social situations	Chose the right people for sharing	3.9
	Found nonjudgmental listeners	3.8
	Shared with a friend	3.8
	Found ways to serve others	3.8
	Found others who experienced similar things	3.8
	Developed healthy relationships	3.8
	Found safe place to share	3.8
	Found validation and assurance I was not psychotic	3.7
	Endured responses when sharing	3.3
	Accepted how people responded	3.2
	Remained active in society	3.1
	Shared with family member	2.7
	Found a workplace that offered support	2.5
2. Supportive environments	Found calm environments	4.0
	Spent serene time alone	3.9
	Spent time in nature	3.9
	Spent time with relaxed people	3.9
	Practiced calm interactions with people	3.9
	Spent time in natural light	3.7
3. Supportive activities	Minimized stress	3.9
	Practiced relaxation	3.9
	Practiced light pleasant exercise such as walking	3.8
	Minimized busyness	3.8
	Practiced simple focused calming activities	3.8
	Practiced regular communication with a trusted friend	3.7
	Practiced rest	3.7
	Practiced self-massage or bathing/showering	3.6
	Got more sleep	3.5
	Moderated sexuality to fluctuating libido	3.5
	Got regular exercise	3.4
	Developed regular sleep cycles	3.3
	Practiced light manual work such as gardening	3.2
	I continued or increased time spent concentrating or reading	2.8
4. Spiritual practices	Studied spiritual transformation	4.0
	Practiced daily prayer	3.9
	Practiced surrender to the divine	3.9
	Read spiritual literature	3.9
	Practiced daily meditation	3.8
	Found supportive spiritual community	3.7
	Visualized grounding my energy field to earth	3.6
	Visualized centering and dropping inside	3.5
	I continued or increased the rigor of my spiritual practice(s)	2.2
5. Self-exploration	Practiced compassion	4.0
	Allowed psychological and spiritual issues to surface	4.0
	Expressed myself through other creative practice	4.0
	Practiced forgiveness	4.0
	Practiced humility	4.0
	Revised my purpose in life	4.0
	Practiced honesty	4.0
	Practiced gratitude	4.0
	Got in touch with my feelings	3.9
	Got in touch with my thought patterns	3.9
	Shifted my sense of reality	3.9
	Accepted responsibility for wanting this STE experience	3.9
	Matched spiritual desires with earthly expectation	3.9
	Accepted returning from expanded state to earthly realm	3.9
	Expressed my inner experience through writing	3.8
	Expressed my inner experience through verbal sharing	3.8
	Explored my unconscious "dark side"	3.8
	Expressed my inner experience through movement	3.8
	Expressed my inner experience through artwork	3.6
6A. Alternative health care	Considered or sought alternative health practitioner	3.8
	Received massages	3.7

(*table continues*)

Table 3 (*continued*)

Thematic group	Practices, habits, and behaviors	Helpfulness rating
6P. Psychiatric and medication	Sought psychotherapy or counseling	3.2
	Considered or sought psychiatric help	2.1
	I chose to take prescription medicine	1.6
	Considered taking prescription medicine	1.5
	Chose to take prescription medicine	1.3
7. Adjusting to heightened sensitivities	Adjusted to awareness of metaphysical events	4.0
	Adjusted to awareness of inner sensations	4.0
	Adjusted to sensitivity to others' suffering	3.9
	Adjusted to sensitivity to light, sound, smell, taste, touch	3.9
	Adjusted to awareness of others' thoughts/feelings	3.8
	Adjusted to sensitivity to toxic chemicals	3.8
	Adjusted to sensitivity to electromagnetic fields	3.6
	Adjusted to ability to predict the future	3.4
8. Healthier nutrition habits	Minimized junk foods	3.8
	Discontinued recreational drugs	3.8
	Discontinued alcohol	3.7
	Discontinued sugar	3.5
	Scheduled regular meals	3.4
	Discontinued caffeine	2.9
	I practiced fasting	2.7
	I ate the same or less heavier foods such as meats, proteins, and/or carbohydrates	2.4

Note. STE = spiritually transformative experience.

ISTEI is lacking in psychometric reliability (internal consistency, test-retest) and validity (factor analysis). A psychometrically sound instrument is yet to be developed—and this study could contribute to that development.

The online survey was created with the delimitation that it was written in English and displayed over SurveyMonkey. Thus only people who could read English and who had access to the Internet could participate in the study. Expectedly, the majority of participants were from primarily English-speaking populations; North American, European, and Australian continents.

Another delimitation was the languaging of the survey, given cultural norms. In many western Christian religions, both historically and currently, language such as communications with the dead, kundalini, out-of-body, and even meditation or yoga may elicit strong aversion, judgment, or at least avoidance from a large part of the United States and Western population. It can be assumed that because the survey contained many of these types of words, a number of people who may have experienced STEs but are strongly identified with religiously conservative thinking, with materialist-oriented scientific circles, or the commonly accepted cultural norm to not take the survey. In summary, people taking the survey were most likely to be American or European, White, educated, religiously liberal, and have access to the Internet. This narrows the generalizability of the results of the study.

Table 4
Mean Ratings of Helpfulness of Practices Within the Nine Thematic Groups

Group no.	Thematic groups	Mean of helpfulness ratings
1	Supportive social situations	3.0
2	Supportive environments	3.4
3	Supportive activities	3.1
4	Spiritual practices	3.2
5	Self-exploration	3.3
6A	Seeking alternative health professionals	3.1
6P	Seeking psychiatric professionals and taking medication	**1.8**
7	Adjusting to heightened sensitivities	3.2
8	Adopting healthier nutrition habits	2.9

Note. The statistically significant lower mean helpfulness rating is shown in bold.

Within this design of the survey was built the delimitation that responders had varying distance from the initial experience, in time, perspective, and completeness of integration. Because their reports were based upon their personal judgments of which practices, behaviors, or habits enhanced the process of integrating their STE, levels of integration became a variable in the analysis of the data. In addition, the accuracy of recall of their progress in integrating their STE may have been altered by the lengthy psychospiritual process of mental and emotional integration of the event.

Another limitation could have been that some of the items on the inventory required sufficient financial support to be able to afford them, such as massage, alternative health practitioners, psychiatrists, and so on. This limitation was addressed within the survey with the added Likert scale choice of "I wish I had the opportunity to have tried this. It would have been very helpful." According to statistical analysis of utilizing this additional scaling by adjusted scoring, the compensation within the instrument appeared successful. There was no statistically significant difference between overall averages of ratings for each item when the "wish I had" answer was weighted equal to "very helpful."

Further Research

This original research study invites further study and validation from future research projects. It is critical that this exploratory study be supported by other evidence. Further experiment with MHI-5 and PTGI-SF for criteria selection, as well as cross-

	1	2	3	4	5	6A	6P	7	8
1		NS	NS	NS	NS	NS	<0.001	NS	NS
2			NS	NS	NS	NS	<0.001	NS	NS
3				NS	NS	NS	<0.001	NS	NS
4					NS	NS	<0.001	NS	NS
5						NS	<0.001	NS	NS
6A							<0.001	NS	NS
6P								<0.001	<0.001
7									NS
8									

Figure 7. The Tukey adjusted *p* value of each pairwise comparison of nine thematic groups showing significant difference of Group 6P. NS = a nonsignificant *p* value. See the online article for the color version of this figure.

validation with other selection instruments would be important for future research into STE integration.

Differentiation between societal adjustment and psycho-spiritual integration was arbitrarily created within this survey for purposes of selection criteria. The interesting patterns of responses suggest that further research on correspondences and distinctions of these two descriptions of types of integration could be beneficial. For example, most people who self-identified as not having completed one also self-reported not having completed the other. Yet graphing the time reported for those who completed both phases of integration showed specific patterns. This is a key point because across the board, participants seemed to adjust to society more quickly than they integrated the experience internally. In many cases this is probably due to necessity (financially supporting themselves), social discomfort (human need to feel accepted), and lack of resources (support in psycho-spiritual integration is lacking in our society). This period of inner turmoil and the stress associated with it generally goes unrecognized. Cross-comparisons with results from the PTGI might bring interesting discoveries, including cross-comparisons with how the inventory ratings corresponded. This direction of inquiry could provide a lens with which to more clearly view the overall integration process.

The integration process itself could be further examined through comparing people who have integrated STEs compared with those who have not, and looking more closely at the range from crisis to integration. Possible stages of spiritual emergence could become identifiable from closer examination of the process, with the potential to destigmatize and depathologize different stages of integration.

Related to this, and possibly utilizing this as well as other data, would be further investigation to determine whether certain practices were useful at different stages of integration. For example, if some practices were rated helpful by most participants regardless of what stage of integration, while other practices were rated helpful primarily by participants who had more fully integrated their STE or reported a longer length of time of integration, this could be an indication that the latter practices were utilized at a time of further maturation in the integration process.

Comparison analysis could be done between the information reported by individuals about their STEs, such as type (e.g., near-death, kundalini, religious conversion, communication with noncorporeal beings), description (mystical, unitive, energetic, out-of-body), duration of experience (seconds to weeks), as well as length of adjustment (days to decades) and of integration (weeks to decades). These could be cross-referenced among the demographic data or inquiry into correspondences with stages of integration.

Five areas, in particular, that deserve further examination stand out in the findings as being less frequently used and showing greater contradiction of reported helpfulness (Brook, 2018). These are areas of investigation that may address particularly weak and/or inaccessible practices in the Western culture but could be vital to guiding and caring for people integrating STEs: (a) alternatives to psychiatric

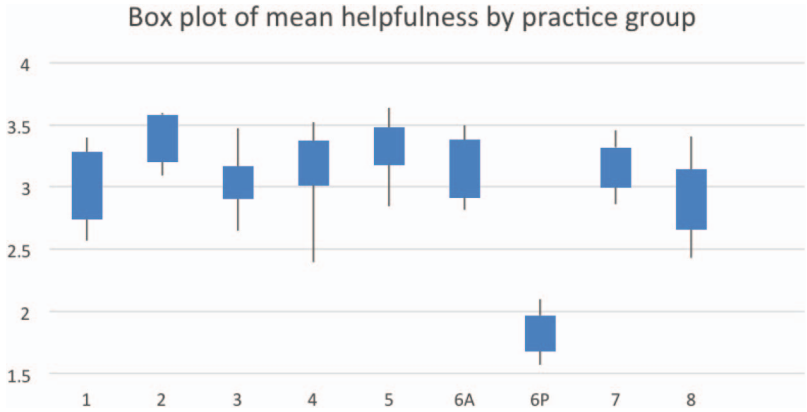

Figure 8. Box plot of pairwise comparisons between Group 6P (psychiatric care and medication) and other thematic groups. See the online article for the color version of this figure.

medication; (b) regular eating, sleeping, and exercise patterns; (c) diet; (d) support in the workplace and within the family; and (e) energetic grounding practices for subtle body health.

Implications

Clinical implications. The ISTEI is a beginning to creating a source of evidenced-based guidelines for clinical practice based on surveying persons with lived experience. It furnishes preliminary findings to answer a call for further research within clinical psychology on the noticeable similarity that disparate types of STEs may mimic psychosis in a way such that they can be addressed together (Vieten & Scammell, 2015). Findings suggested strong correspondence between the broad diversity of people and experiences of commonality of what practices are most beneficial for integration of STEs.

One of the clearest and most potent findings from this research study is that respondents reported they seldom found psychiatric medication helpful to their integration processes and usually found it not helpful. This finding from the ISTEI survey is particularly important because of the prevalence of misdiagnosis within spiritual emergency situations. Psychiatric emergencies should be screened for the possibility that the patient is experiencing distress during a spiritual crisis. Increased cost, increased complications within caregiving facilities, and continued confusion within clinical bodies of knowledge prolong suffering and inadequate care, which can be avoided by promoting education regarding best practices for assisting in integrating spiritual emergencies.

Religious and pastoral implications. The difficulties faced by clergy and pastoral counselors can be similar to those of medical clinicians if they have no experience or training to recognize the characteristics of this kind of spiritual struggle. Religious professionals tend to either refer the person to psychiatric treatment, or interpret the situation as demonic. Many people avoid even approaching pastoral counselors or clergy because of apprehension of this very thing. Religious professionals trained in recognizing spiritual crises of this kind would be able not only to refer people struggling to integrate STEs to helpful resources, but also would be in ideal positions to set up safe and supportive opportunities for them and their families.

Implications for individuals, friends, and families. Evidence from this study shows strong implications that STErs employ a great amount of inner knowing and self-awareness in their journey toward integrating their experience. This indicates the importance of supporting STErs' sense of what they need, rather than disempowering them through diagnosis, treatments, or any intervention that might be at odds with their own intuition or their personal sense of what is beneficial. Evidence for this occurs in this study in several forms: (a) significant evidence ($p < .001$) that those who self-identified as integrated or not yet integrated corresponded with whether they met the cutpoint for the MHI-5, which shows that STErs are aware of what integrated versus unintegrated entails from within the process; (b) items requiring differentiation between adjusting to society and integrating intrapsychic processes were responded to by participants in predictable ways, suggesting that STErs are very aware of how their integration process unfolds; (c) significantly corresponding ratings ($p < .0001$) of how helpful and how often the practices are used between participants shows a common intuitive knowledge available to STErs; and (d) significant difference ($p < .001$) in mean ratings of the one out of nine groups of practices rated as minimally beneficial or not beneficial was being under psychiatric care and taking medication. These results suggest not only that psychiatric medication may be unnecessary and/or contraindicated, but suggest that self-determined practices and courses of treatment are likely most beneficial. The evidence supports trusting that these individuals can assess themselves accurately, are aware of their own process of integration, and can best determine their own path to integration.

Conclusion

Results from this study furnish a pool of information that can potentially be introduced across a spectrum of disciplines: psychiatry, psychology, medicine, religion, anthropology, cultural studies, and community services. The study offers confidence in concluding that there is a consistency of opinion among a large diversity of participants and experiences regarding what practices were helpful in integrating STEs. Findings suggest that individuals in the process of integrating STEs naturally and intuitively seek out practices, habits, and behaviors that are the most beneficial, given that heretofore in the United States and related cultures there has been little formal clinical or public guidance for this process. The ISTEI is a step toward developing a comprehensive set of evidenced-based guidelines to assist in that process.

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