ANNEKE SIPS

WISDOM OF PSYCHOSIS

Navigating the Intelligence
of Altered States

Selected excerpts for preview
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Wisdom of Psychosis
Navigating the Intelligence of Altered States by Anneke Sips

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Author
Anneke Sips, RN

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You're not lost, you're here

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ENDORSEMENTS

'*Wisdom of Psychosis* is a clear and accessible work that brings sophistication to the treatment and understanding of features commonly associated with psychosis. Drawing on Polyvagal Theory, trauma and attachment science, and decades of clinical experience, Anneke Sips thoughtfully deconstructs explanatory narratives that have often obscured these experiences. The book offers a timely, optimistic, and compassionate perspective on stabilization, healing, and rehabilitation grounded in safety, relationship, and care.'

— Stephen Porges, PhD, originator of Polyvagal Theory

'Our collective fear of psychosis is based on a fundamental misunderstanding of human consciousness, and in this groundbreaking, deeply informative and pragmatically supportive book, psychosis is deconstructed and reconstructed for what it truly is and can be. Wisdom of Psychosis goes where few have had the courage to venture, beyond labeling to listening, in service of the human journey home to self.'

— Dr. Kelly Brogan, New York Times bestselling author & holistic psychiatrist

PART 1

UNDERSTANDING THE SPECTRUM OF PSYCHOSIS AND CONSCIOUSNESS

Everyone wants to rescue or save you. Everyone thinks they know what will fix you. The medical system offers medication to quiet the noise. The wellness industry offers bio-hacking protocols to optimize you. The gurus offer chakra healing and quick enlightenment. *'The doctor said an antipsychotic might help me forget what the trauma said,'* Andrea Gibson writes in 'The Nutritionist.' But what if forgetting isn't the goal? What if the trauma has something to say? What if the altered state carries meaning? What if the crisis is also a catalyst? (find the full poem is in the playlist at www.wisdomofpsychosis.com).

Part 1 offers frameworks for understanding, not to replace your experience with theory, but to give you language, context, and permission to see your experience differently.

We'll begin by reframing psychosis itself, questioning the labels and categories that have shaped how we think about these experiences. We'll look at the medical model: its uses and its limits. We'll explore what's happening in the brain and body during altered states, and how trauma weaves through so much of what gets called *mental illness*. We'll reclaim mysticism and sensitivity from pathology. And we'll draw on ancient maps of consciousness, particularly Sāṃkhya philosophy, to orient ourselves in territory that Western psychiatry has no language for. By the end of Part 1, you'll have a foundation. Not answers, but better questions. Not certainty, but discernment.

THE JOURNEY STARTS HERE.

CHAPTER 1

REFRAMING PSYCHOSIS

'The only way to make sense out of change is to plunge into it, move with it, and join the dance.'

— Alan Watts

'Psychosis is man's greatest mystery,' says Dr. Jim van Os, a recovery-oriented psychiatrist and professor of psychiatric epidemiology. According to Van Os, psychosis is not just a disconnection from reality, but rather an over-connection — a state of 'hyper-significance.' In this heightened state, everything around the person seems filled with personal, often fearful, meaning. Anxious emotions filter the world, and the individual becomes absorbed in an experience that others may struggle to comprehend. In the West, psychosis is typically viewed as a mental health disorder characterized by a disconnection from reality, with symptoms ranging from altered thinking and emotions to distorted perceptions and behaviors. Yet Dr. van Os and others have highlighted that psychosis is a common, human experience, one that touches everyone from time to time. He notes, 'A little psychosis is not bad; it happens to many people.' But what does it mean to 'have' a psychosis? Just as one can catch the flu without becoming the flu, so too can one experience psychosis without being psychotic.

Psychosis is an experience, perhaps one that is unique or difficult to share with others, but it remains an embodied human experience. The difficulty often arises when these experiences, which may feel deeply meaningful to the person, are labeled as 'strange' or 'crazy' by those around them. Many people report receiving messages through plants, objects, or visions, or a transmission from another realm. Is this a problem? Communication is more than hearing with the ears; it is a sensory experience involving all aspects of our being. The brain creates stories from the input we receive through our senses, and our emotions shape the interpretation of these stories. Our mental state plays a significant role in how we perceive and react to these experiences. And how others respond to us can further shape our reactions.

Psychosis itself is not a singular condition. It can be part of a range of mental health issues such as schizophrenia, bipolar disorder, or severe depression. It can also be triggered by substance use, medical conditions, or neurological disorders. Psychotic episodes may be brief or chronic, isolated or recurring.

Some common features of psychosis from a Western psychiatric point of view include:

- **Hallucinations**: Perceiving things that others do not, such as hearing voices or seeing visions. Auditory hallucinations are the most common, but visual, tactile, and other sensory experiences can occur. Interestingly, if these voices are benign or positive, they are often not considered psychotic but an anomalous experience, but if the message is disturbing, it might be labeled as such.
- **Delusions**: Firmly held false beliefs, such as paranoia, grandiosity, or somatic concerns. These beliefs persist despite clear evidence to the contrary and can be distressing for the individual.
- **Disorganized thinking**: Individuals may struggle to organize their thoughts and communicate clearly, resulting in disjointed or incoherent speech.
- **Impaired insight**: People in psychosis may not realize their perceptions or thoughts are unusual, making them resistant to help or treatment.
- **Emotional dysregulation**: Emotions can become intense and unpredictable, leading to anxiety, fear, or even anger and agitation.
- **Social and occupational impairment**: The ability to function in daily life, maintain relationships, and work is often impacted by psychosis, making it difficult for individuals to navigate everyday life.

Psychosis often requires additional care, including psychiatric intervention and treatment. It commonly manifests in paranoid delusions, auditory hallucinations, disorganized thinking, and sometimes in what are called 'negative symptoms' like emotional withdrawal. Later I will explain what negative symptoms are. Psychotic episodes often first appear in adolescence

and can create feelings of exhaustion, agitation, and emotional burnout. The experience of psychosis, though distressing, may also offer a path to understanding, growth, or recovery, if we approach it with patience, compassion, curiosity, and the right support. The danger lies in misinterpreting these profound experiences as purely pathological, which can bring or deepen trauma and push the individual further from balance.

A NORMAL HUMAN EXPERIENCE

Psychosis, despite its clinical associations, can be viewed as part of the normal spectrum of human experience. We all have the potential for psychotic-like experiences, such as hearing an inner voice advising us or imagining a loved one speaking to us, even when they are not physically present. These are experiences many of us encounter, and they exist on a spectrum. For some, these experiences remain mild and infrequent; for others, they can become more intense and disruptive, leading to distress or a clinical diagnosis. The key distinction lies in the severity, duration, and impact on one's life. Some of us may experience fleeting psychotic-like symptoms, unusual beliefs or perceptions, without meeting the criteria for a full-blown psychotic disorder. These subclinical experiences may come and go without significantly affecting daily life. Stress-induced or brief psychotic episodes can also occur in response to intense emotional or environmental stress, even in individuals without chronic psychotic conditions. These episodes often resolve as the stress subsides, illustrating that psychosis can be context-dependent, transient, and far more common than we realize.

Cultural interpretations further complicate the picture. One culture might classify something as psychosis, while another might view it as a spiritually significant experience. In some indigenous cultures, hearing voices might be considered communication with the spirit world, whereas a Western context would label it as a symptom of mental illness. Drug-induced psychosis adds yet another dimension. Substances like hallucinogens or stimulants can temporarily alter perception and induce psychotic symptoms. These too typically dissipate when the effects of the substances wear

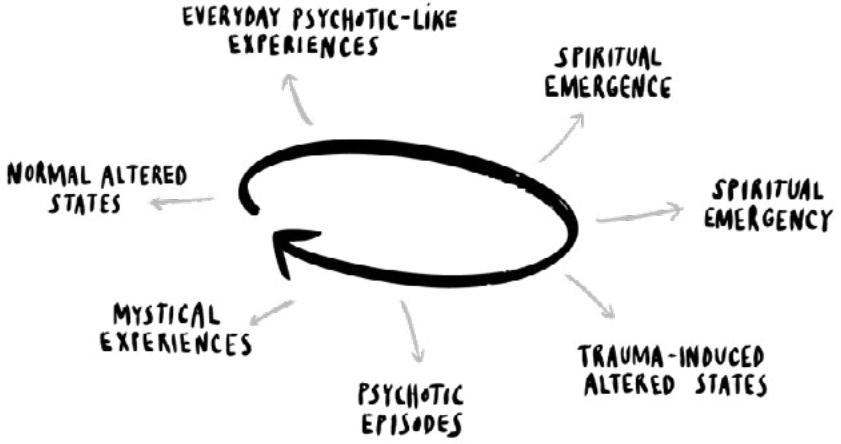
off. While these variations are important to understand, differentiating between these fleeting, less severe episodes and clinically significant psychotic disorders such as schizophrenia is essential. Persistent psychosis often requires clinical support and treatment to manage its profound impact on daily functioning.

FROM ORDINARY TO EXTRAORDINARY: THE SPECTRUM OF HUMAN EXPERIENCE

Rather than viewing psychosis as a binary state (sick vs. healthy), this book embraces a spectrum understanding. We all experience this spectrum:

- **Normal altered states**: daydreaming, hearing inner voices, intense déjà vu, feeling a deceased loved one's presence.
- **Everyday psychotic-like experiences**: brief unusual perceptions or beliefs that come and go without disrupting life.
- **Spiritual emergence**: gradual awakening experiences that can be integrated with the right support.
- **Spiritual emergency**: sudden, overwhelming openings requiring immediate grounding.
- **Trauma-induced altered states**: dissociative experiences arising from unprocessed wounds.
- **Psychotic episodes**: profound breaks from consensus reality that require stabilization.
- **Mystical experiences**: direct encounters with the numinous that may look like psychosis to observers.

The point here is that psychotic-like experiences are part of normal human consciousness. Most experiences contain elements of multiple types. The boundaries are fluid, not fixed. What matters is severity, duration, and impact on functioning.



THE SEARCH FOR MEANING

At the heart of the psychotic experience, there is often a deep search for meaning. In a world that can feel fragmented and disconnected, psychosis can be seen as an exaggerated attempt to make sense of everything at once. As Dr. Jim van Os suggests, psychosis is not just a breakdown but also a state of 'hyper-meaning', where an individual's mind over-assigns significance to ordinary events, often in ways that create fear and anxiety.

Imagine walking through a dark forest after watching a horror movie: every rustling leaf might signal a threat, every shadow a potential danger. This heightened state of suspicion mirrors psychotic experiences, but most times we can reorient ourselves and discern what is real. However, in psychosis, this ability to test reality becomes impaired. People may experience extreme suspicion (delusions) or hear voices they can't control (hallucinations), making everyday life increasingly challenging. Psychosis can also feel like a deep spiritual experience. For some, the experience carries profound messages; for others, it is purely distressing. The meaning we assign to our symptoms profoundly shapes our journey toward recovery. If one believes psychosis is an irreversible brain disease requiring lifelong medication, this belief may create a sense of hopelessness. Conversely, if someone views

psychosis as part of a spectrum that can be understood and managed, it can provide a path toward healing and integration. Dr. van Os suggests, 'Psychosis is not necessarily a brain disease; we simply don't know. It seems more like a human trait that has become out of control, much like depression or anxiety.' Recognizing this helps shift the conversation from one of pathology to one of possibility, an opportunity for growth, healing, and self-understanding.

THE THRESHOLD OF CRISIS

Mild psychotic experiences are common, but when they intensify, last longer, or co-occur with conditions like depression or mania, they can become overwhelming. A person may perceive patterns and connections everywhere, becoming absorbed in elaborate webs of meaning, hidden messages, or perceived threats. This hyper-significance can dominate their thinking and behavior. What starts as heightened sensitivity can escalate to a point where every day functioning becomes difficult. For example, someone might experience a profound sense of being chosen for a special purpose, perhaps believing they hold a position of great importance, and this belief may lead them to take actions that create real-world consequences for themselves and those around them. From the inside, their experience follows its own coherent logic; from the outside, observers see disconnection from shared reality. While family and clinicians may perceive the behavior as concerning, the person experiencing psychosis often feels like the world around them has shifted, with others behaving strangely or even threateningly toward them. This perception of threat activates the nervous system's survival responses, which can further intensify the experience.

Understanding psychosis requires us to hold this paradox: it can be both a crisis requiring support AND a meaningful human experience with the potential to teach us about consciousness, vulnerability, and our deep need for connection. When we reduce it to mere pathology, we risk missing the person's story, often rooted in unmetabolized trauma. We also miss the genuine possibility for post-psychotic growth — something that can

emerge when we approach with curiosity rather than judgment. To fully appreciate why this integrative framework matters, we need to understand how profoundly our cultural lens shapes what we see. The way we interpret and respond to psychotic experiences has changed dramatically across history, revealing more about our collective worldview than about the nature of the experiences themselves.

BEYOND THE BINARY: A FRAMEWORK FOR DISCERNMENT

Given this complexity, how do we make sense of these experiences? Most discussions about the spectrum of mental states force a false binary: insanity OR divinity. We're expected to choose sides, either dismiss all spiritual experiences as brain chemistry gone wrong or romanticize every psychotic break as enlightenment. The book Insanity & Divinity (Gale et al., 2013) offers something more useful: a framework for discernment rather than diagnosis. They suggest examining four dimensions: language (does it communicate insight or create isolation?), behavior (does it increase capacity or diminish it?), mission (is there coherent purpose emerging over time?), and outcome (where does this lead as it unfolds?). This framework recognizes that unconventional speech may carry deep wisdom, that alarming behavior might serve integration, and that we often cannot distinguish spiritual emergence from mental health crisis at the moment — only the trajectory over time reveals the difference. What I've learned over two decades of this work is that as we open our view and develop discernment, what once seemed bizarre begins to make sense. The strange becomes less strange. You may notice this shift in yourself as you read this book and begin applying these perspectives in your practice and life, suddenly you'll hear the coherence beneath unusual language, recognize the wisdom in what others dismiss as madness. But even this helpful framework still frames the question as either/or. What I've learned from sitting with people in psychiatric crisis is that the more useful questions don't ask us to categorize at all. Instead of 'insanity or divinity?' we should be asking: What supports integration versus fragmentation? What serves healing versus harm? What increases

capacity versus decreasing function? What connects versus isolates? These questions honor both the reality of overwhelmed nervous systems AND the possibility that something genuinely transformative might be emerging. They don't require us to choose between neuroscience and spirituality; they ask us to track what serves the person's wholeness.

A BRIEF HISTORY OF PSYCHOTIC PERCEPTIONS AND MISCONCEPTIONS

Psychotic experiences, often associated with conditions like schizophrenia and schizoaffective disorder (more in the next chapter), have long been a subject of fascination and misunderstanding. Over the centuries, interpretations of psychosis have oscillated between mystical reverence and stigmatized pathology. From ancient civilizations to modern psychiatric practices, how we perceive and respond to these experiences has shifted dramatically as cultural and medical frameworks evolved. In ancient cultures, symptoms of psychosis were frequently attributed to divine or demonic possession. Civilizations like those in Mesopotamia, Egypt, and Greece viewed hallucinations or unusual behavior as evidence of spiritual intervention, whether as punishment or sacred connection. This often led to the marginalization and mistreatment of those experiencing such states, with responses ranging from exorcisms to religious rituals intended to 'purge' these perceived spiritual disturbances.

The Middle Ages saw a particularly dark period for those perceived as mentally ill. During this time, psychosis was frequently conflated with witchcraft, heresy, or sin, leading to harsh punishments, including torture and execution. People displaying signs of psychosis were often locked away in asylums, segregated from society. The concept of mental illness was poorly understood, and individuals experiencing what we now recognize as psychotic states were persecuted rather than supported.

The Enlightenment marked a shift toward more rational, science-based approaches to understanding psychosis. Reformers like Philippe Pinel in

France and William Tuke in England pioneered more humane treatments for individuals with mental illness, rejecting the idea of possession in favor of medical explanations. They believed psychotic perceptions were rooted in physical imbalances and advocated for kindness and therapeutic interventions rather than confinement and punishment.

The 19th century saw the rise of asylums, intended to treat individuals with mental illnesses, but they often became places of isolation and suffering. Psychosis was considered a form of madness, and treatments during this time included confinement and methods we would now recognize as brutal, hydrotherapy, restraints, and isolation. However, the late 19th and early 20th centuries brought psychological theories into prominence, with figures like Sigmund Freud contributing to a deeper understanding of how the unconscious mind could shape thoughts and perceptions.

In the mid-20th century, significant advancements in psychopharmacology brought the development of antipsychotic medications, offering relief for many people experiencing psychosis. These medications became essential tools for managing symptoms like hallucinations and delusions, though the treatments were not without their own challenges and side effects, a reality that continues today.

Modern psychiatry takes a more integrative approach to understanding psychotic experiences, incorporating neurobiological, psychological, and sociocultural factors. The roles of brain chemistry, trauma, and social environment in the development and expression of psychosis are now better understood. Treatments are increasingly focused on supporting recovery, well-being, and empowerment, recognizing the potential for individuals to live fulfilling lives even with experiences of psychosis.

The anti-psychiatry movement of the 1960s questioned the medicalization of mental illness, critiquing the over-reliance on medication and institutionalization. While extreme at times, this movement contributed to a more nuanced understanding of mental health and emphasized the importance of human rights and dignity in psychiatric treatment. In recent

years, a recovery-oriented approach has gained traction in mental health care. This perspective highlights the potential for individuals to manage and even transform psychotic experiences, focusing on reducing distress, promoting empowerment, and supporting people in their healing journeys.

UNDERSTANDING STIGMA

Yet despite these advances, stigma persists. Historically, misconceptions about psychotic sensitivity and psychosis have fueled widespread stigmatization, misunderstanding, and mistreatment of those experiencing these states. Terms like 'lunatic', 'madman', 'crazy', and 'insane' were commonly used to dehumanize individuals, perpetuating harmful stereotypes that reduced complex human experiences to limiting labels. Popular culture has particularly contributed to this stigmatization through sensationalized portrayals that depict individuals with psychosis as dangerous or violent, reinforcing inaccurate beliefs. In reality, individuals with mental health conditions are far more likely to be victims of violence than being perpetrators, a truth often overlooked by these misrepresentations. The French philosopher Michel Foucault explored the marginalization of those deemed 'mad' in his influential work Madness and Civilization (1961/1965). He traced society's treatment of individuals with mental illness from the Middle Ages, where madness was often integrated into society, to the 'Great Confinement' of the Classical Age, when people with mental illness were systematically isolated in asylums. This shift, he argued, represented not humane progress but another form of social control. A key contributor to ongoing stigmatization is the legal framework surrounding mental illness, particularly the defense of 'not guilty by reason of insanity.' This legal concept is widely misunderstood. Contrary to popular perception, individuals found not guilty by reason of insanity are not simply set free but typically undergo extensive psychiatric treatment and may be committed to mental health facilities for long-term care. However, the existence of such legal frameworks continues to fuel the false belief that people with psychosis or schizophrenia are inherently dangerous to society.

One crucial contemporary issue is the difficulty of revisiting and, where appropriate, revising psychiatric diagnoses. Once a diagnosis is given, it can be incredibly difficult to change, even if an individual's experience shifts significantly. This diagnostic inflexibility can trap people in limiting labels that no longer reflect their current state or potential.

MOVING FORWARD

In recent decades, efforts have been made to challenge these misconceptions and promote a more empathetic understanding of mental health. By viewing mental health as a spectrum rather than a binary of 'illness' or 'sanity', we can begin to break down the walls of stigma. This perspective allows us to see psychotic sensitivity as part of a broader range of human experiences, recognizing that we all move across this spectrum at different points in our lives.

This broader understanding encompasses psychotic spectrum conditions, sensitivity to altered states, and culturally celebrated forms of consciousness in different parts of the world. Some experiences that might be pathologized in one cultural context are valued as spiritual or visionary experiences in others, highlighting the cultural relativity of what we define as normal consciousness. Through awareness, education, and active efforts to challenge stereotypes, we can build a more compassionate society that supports those experiencing mental health challenges. This includes creating systems that allow for diagnostic flexibility and recognition of recovery and change.

THE IMPACT OF LABELING

The medical model's emphasis on diagnostic labels, like schizophrenia, can have unintended consequences, often leading individuals to feel defined solely by their diagnosis. These labels, rather than being viewed as temporary or contextual, are frequently perceived as permanent, creating both social and internal stigma. Individuals may begin to see themselves as broken or irreparably flawed, which compounds feelings of isolation.

Dr. Jim van Os emphasizes the need to move away from viewing psychosis or schizophrenia as static, lifelong brain diseases. He argues that labeling these profound experiences as disorders can alienate individuals and pathologize what may be existential or spiritual challenges, rather than purely medical conditions. This act of labeling creates an 'othering' effect, which deepens the sense of separation and reinforces disempowerment. Such labeling often becomes a self-fulfilling prophecy in mental health care. When professionals present a diagnosis with a pessimistic prognosis, it can profoundly impact an individual's self-esteem, sense of agency, and motivation to heal. This negative framing discourages belief in recovery and places unnecessary barriers to progress. Rather than fostering hope, it entrenches limitations, making it more difficult for individuals to envision a life beyond the diagnosis, thus hindering their engagement in the recovery process. Understanding this history — how we've swung between extremes of mystification and medicalization, how stigma has shaped both individual lives and collective responses — brings us to a critical question: Is there another way? Can we hold the complexity of psychotic experiences without reducing them to either pure pathology or pure spirituality?

MY APPROACH: THE THIRD PATH

Before we continue, I want to be clear about the stance I'm taking — because it matters for how you'll read what follows. This book explores both mainstream psychiatry and alternative spiritual communities with honesty and care. I do this not from a place of judgment, but from years of experience working within and alongside both worlds, seeing what helps and what sometimes falls short.

Where mainstream psychiatry can fall short

Over-reliance on medication as first-line treatment. The reduction of complex human experiences to diagnostic categories. The challenge of

addressing underlying trauma and disconnection within brief clinical encounters. The use of coercion can create more harm than healing. When the primary goal becomes symptom suppression without addressing root causes, people can remain dependent on systems that don't fully serve their wholeness.

Where alternative and spiritual communities can fall short

The use of transcendent language that sometimes bypasses necessary healing work. The creation of guru dynamics that can replicate the same power imbalances they critique in mainstream medicine. The belief that positive intentions alone can heal deep wounds. The (sometimes implicit) shaming of people who need medication or conventional support. When spirituality becomes a way to avoid feeling pain rather than a path toward genuine integration, it can create its own challenges.

The third path I offer is integrative

It recognizes that some people need medication AND embodied practices. That crisis sometimes requires intervention, AND we can make that intervention more humane and relational. That altered states can contain wisdom AND be profoundly destabilizing. That spiritual experience is real AND needs grounding in body and community. This isn't anti-medication. It isn't anti-spirituality. It's both/and thinking. This approach is:

- Trauma-informed: recognizing that disconnection and dysregulation often have roots in unresolved trauma
- Relationally grounded: understanding that healing happens in relationship, not in isolation
- Embodied: bringing awareness back to the body, breath, and nervous system
- Spiritually aware without bypass: honoring the sacred dimension while not using it to avoid necessary human work

- Collaborative: viewing the person as partner in their healing, not passive recipient of treatment
- Culturally humble: recognizing that different cultures have different frameworks for understanding consciousness

You'll see this middle-way philosophy woven throughout the book in how I talk about sensitivity (capacity, not just pathology), in the practices I offer (integrating yogic wisdom with neuroscience), in the vision I present for the future (Terrapy as ecological, relational model).

Part 1 will give you a conceptual framework.

Part 2 will offer embodied practices.

Part 3 will zoom out to the bigger picture, exploring what needs to change in mental health systems, what post-psychotic growth looks like, and what a new paradigm (Terrapy) might offer.

For now, just know that this book meets you where you are, honors the complexity of your experience, and offers a path forward that doesn't require you to choose between medical help and deeper healing. You can have both.

Are you ready?

CHAPTER 4

TRAUMA AND PSYCHOSIS

'Trauma happens when any experience stuns us like a bolt out of the blue; it overwhelms us, leaving us altered and disconnected.'

— Peter A. Levine

In mental health care today, the relationship between trauma and psychosis is often misunderstood, with trauma's role being underplayed in psychotic experiences. Dr. Gabor Maté, a renowned expert in trauma and addiction, emphasizes this connection: 'All the diagnoses you deal with: depression, anxiety, ADHD, bipolar illness, PTSD, even psychosis, are significantly rooted in trauma. They are manifestations of trauma.' Yet our mental health system continues to separate these experiences into distinct categories, as if the brain develops in isolation from what happens to it. This artificial boundary has profound consequences, not just for diagnosis, but for how we understand consciousness itself.

Sarah's story: when labels miss the truth

Sarah was nineteen when she first heard the voice. It started after she moved into student housing, a cramped room with thin walls where she could hear every footstep, every conversation in the hallway. The voice was male, menacing, telling her she was worthless, that she deserved to suffer, that he was watching her. Within weeks, she stopped attending classes. She covered her windows with blankets. She stopped eating in the communal kitchen because she was certain others could hear her thoughts. Her roommate brought her to the emergency room. The psychiatrist on call spent twenty minutes with her, noted the auditory hallucinations and paranoid ideation, and diagnosed her with first-episode psychosis. She was started on antipsychotic medication.

But Sarah's story didn't begin at nineteen. In our first meeting at the early intervention clinic, I asked Sarah about her life before the voice

appeared. She was hesitant, measuring her words carefully. But slowly, the timeline emerged: her stepfather had sexually abused her from age four to sixteen. The abuse happened in her bedroom, late at night, when she couldn't escape but also in the bathroom and other places, like the car or in other people's house, where also other adults and children were involved in the abuse. His voice, low, threatening, telling her to stay quiet, telling her she was worthless, became the soundtrack of those years.

But the abuse was more than physical violation. Her stepfather was skilled at psychological control. He would tell her she was crazy, that she was dangerous to others, that she imagined things, that no one would believe her if she told. 'You're not like other children,' he'd say. 'You're different. Disturbed. People can see it.' When she showed normal reactions to his abuse, like fear, confusion, distress, he'd use those reactions as proof. 'See? You're losing it. You're not right in the head.'

Sarah internalized this completely. By the time she was a teenager, she genuinely believed she was fundamentally different, broken in ways other people weren't and, in a way, feeling guilty of the abuse herself. The deep insecurity this created isolated her from peers. She couldn't trust her own perceptions, her own reality.

She had tried to reach out once. At eleven years old, before the sexual abuse worsened but emotional manipulation was already underway, she told a neighbor that her stepfather scared her, that something felt wrong. The neighbor, a kind woman who'd known the family for years, smiled sympathetically and said, 'Oh honey, your stepfather is such a nice man. He loves you so much. You know you can be a bit sensitive, a bit different from other children. Maybe you're just having a hard time adjusting to the new family.'

The message was clear: the problem was Sarah, not him. And one part of Sarah started to think that the neighbor was involved in the abuse too, as she was protecting her stepfather.

When Sarah finally disclosed the sexual abuse at sixteen, her mother didn't believe her. By then, years of being told she was 'crazy,' 'different,' 'disturbed' had laid the groundwork. Her mother saw a troubled, difficult

teenager making wild accusations against a man who'd been nothing but patient with her problems. The family fractured. Sarah moved out at seventeen to live with an aunt, finished high school, and thought she'd left it all behind.

Until the dorm room. Until the thin walls. Until the hypervigilance that had been her survival mechanism for years suddenly had nowhere to go. The voice she was hearing? It was her stepfather's voice. The paranoia about others hearing her thoughts? It mirrored the shame and exposure she'd felt during years of abuse, the terror of being discovered, the experience of having her inner world constantly invaded. The inability to eat in shared spaces? A nervous system still convinced that being visible meant being vulnerable.

WAS THIS PSYCHOSIS? OR WAS THIS TRAUMA?

The psychiatric resident who initially diagnosed her wasn't wrong to see psychotic symptoms. They were there. But he'd asked the wrong questions, or rather, he'd stopped asking questions too soon. It took three months and a trauma-informed approach to uncover what Sarah's symptoms were trying to communicate. And even then, the full story emerged gradually. What I've learned over years of this work is that when I listen carefully and deeply, when safety and connection grow, what initially sounds 'too crazy to be true' in survivor stories often expands into a larger narrative that makes profound sense. Details emerge that create logic in the bigger picture. Sarah's experience of hearing her stepfather's voice wasn't random neurochemistry; it was her system trying to process years of psychological torture that had convinced her she couldn't trust her own mind.

The 'crazy' label her stepfather imposed had done exactly what it was designed to do: make her doubt her own reality so completely that even her psychotic symptoms became self-fulfilling prophecy. He'd called her crazy for years. Now she had a psychiatric diagnosis that seemed to prove he'd been right all along. This is the confusion that shapes, and misshapes, so

many lives. Understanding trauma isn't just about adding another diagnosis to someone's chart. It's about recognizing that what looks like a brain breaking down may actually be a nervous system doing exactly what it was trained to do: survive.

THE 'INNOCENT' GASLIGHTING WE DON'T NOTICE

Before we go deeper into understanding trauma and psychosis, we need to address something uncomfortable: we gaslight people experiencing altered states all the time, often with the best intentions. Think about common responses when someone shares an unusual perception or experience:

- 'That didn't really happen'
- 'You're just stressed / tired / overthinking'
- 'It was just a dream'
- 'You're being paranoid'
- 'That's not possible'
- 'You need to get back to reality'
- 'Don't be silly, there's nothing to be afraid of'

These responses feel innocent, even caring. We're trying to reassure, to bring the person 'back to reality,' to help them feel better. But what we're actually doing is telling them: Your experience isn't real. Your perceptions can't be trusted. What you know to be true isn't true.

This is gaslighting, even when we don't intend it that way.

Family members do this constantly with loved ones in altered states. 'Mom, there are people in my room.' 'No, honey, there's no one there, you're just imagining it.' The family member means well. They're trying to comfort. But they're also invalidating the person's actual experience, because there IS something in that room: terror, perhaps. Traumatic memories taking form. Parts of the psyche trying to be seen.

Mental health professionals do this too. 'These voices aren't real.' 'Your beliefs don't match reality.' 'We need to get you back to baseline.' We position ourselves as arbiters of what's real, inadvertently (or sometimes deliberately)

communicating that the person's experience is false, disordered, meaningless. Even trauma-informed practitioners can fall into this pattern:

- 'That couldn't have happened that way.'
- 'Memories from that age aren't reliable.'
- 'Are you sure you're not mixing up what you read with what you experienced?'

We think we're being appropriately cautious, but we're participating in the same invalidation that abusers weaponized. The difference between innocent gaslighting and malicious gaslighting isn't the impact; it's the intent. Both tell someone their reality can't be trusted. Both create doubt and shame. Both can deepen disconnection from self.

What makes this particularly insidious is that people in altered states or psychotic experiences often have fragile trust in their own perceptions already. They're questioning what's real. They're frightened by their own mind. When we add our voices to that doubt, even gently, even 'supportively', we reinforce the very disconnection that's causing their distress.

A different approach asks: 'What is this experience trying to communicate? What does it feel like for you? What meaning does it hold?' This doesn't mean we agree that the literal content is objectively true — it means we honor that the experience itself is real and meaningful for the person living it.

Sarah's stepfather used gaslighting maliciously to maintain control and avoid accountability. But the neighbor who dismissed Sarah's fear, the psychiatrist who saw only symptoms without asking about their meaning, the medication-focused approach that sought to eliminate her voice without understanding it, these were all forms of innocent gaslighting that reinforced the same message: You can't trust what you know.

We need to become aware of this pattern. The language we use matters. The questions we ask or don't ask matter. Whether we're curious about someone's experience or dismissive of it matters. Even when our intentions are caring, if our response is 'that's not real,' we're participating in invalidation that can deepen suffering.

UNDERSTANDING TRAUMA: LAYERS AND COMPLEXITY

Trauma, derived from the Greek word for 'wound', is increasingly recognized as a major contributor to psychological distress. As Dr. Gabor Maté explains, 'Trauma is when there is a loss of feeling and reduced flexibility in responding to the world. This is a response to a wound.' Trauma refers to experiences that overwhelm our capacity to cope, leaving us altered in how we perceive safety, connection, and reality itself. It's not limited to physical threats; trauma encompasses anything that threatens our physical, emotional, social, financial, or spiritual survival. What makes trauma so complex is that no two people respond identically. We're shaped by our unique genetic makeup, history of previous trauma, available support, and developmental stage when trauma occurs. A child of five and an adult of thirty-five will process the same event entirely differently — not because one is weaker, but because their nervous systems are at different stages of development. Human beings are inherently resilient. We're born with the capacity to overcome trauma. Trauma is not permanent; it is transformable. The healing process can lead to profound emotional and spiritual transformation, opening a gateway to deeper understanding of ourselves, if we're given the right support and approach.

Sources of trauma

Trauma arises from both catastrophic and everyday experiences:

Obvious sources: war, natural disasters, severe abuse or neglect, witnessing violence, catastrophic injury or illness, death of loved ones

Less obvious sources: minor accidents, medical procedures, feeling unloved or criticized, parental struggles (illness, addiction, financial stress), moving houses, changing schools, being teased or bullied, not being picked for teams, harsh punishment.

Sometimes trauma stems not from what happened, but from what we feared would happen, the constant anticipation of punishment,

abandonment, or loss leaves lasting imprints even when feared events never occur. Like walking a mine field, the threat itself becomes the wound.

Types of trauma: a spectrum of experiences

Understanding different types of trauma helps us recognize why people respond so differently to overwhelming experiences:

Single-event trauma arises from an isolated incident such as a car accident or natural disaster. These are often easier to integrate if no pre-existing trauma or mental health challenges were present. The person tends to be triggered primarily by events closely related to the initial incident.

Complex trauma arises from repeated, prolonged exposure to distressing interpersonal events, such as childhood abuse or chronic domestic violence. This is where Sarah's experience falls, the years of ongoing violation and psychological manipulation that shaped her entire developmental period. Individuals with complex trauma often experience high levels of fragmentation and struggle in interpersonal relationships, not because they're inherently damaged, but because their templates for safety and trust were formed in contexts of danger and betrayal.

Developmental trauma affects individuals during their formative years, deeply shaping personality and brain development. As trauma researcher Dr. Bessel van der Kolk notes, when children grow up without caregivers who help them make sense of distressing emotions, they often struggle to interpret or regulate those emotions as adults. This can manifest in patterns such as alexithymia (difficulty recognizing or naming one's emotions) or what gets labeled as borderline personality disorder, though these aren't disorders as much as adaptations to impossible circumstances.

Transgenerational trauma passes down through generations, often in families affected by war, displacement, or systemic violence. Research into

epigenetics shows that traumatic experiences can alter gene expression, making descendants more susceptible to psychological distress. This isn't genetic destiny but it's biological memory seeking resolution.

The ACEs study and long-term impact

The Adverse Childhood Experiences (ACEs) study demonstrated the profound long-term health effects of early trauma. It showed that childhood trauma is strongly linked to severe adult medical and psychological conditions, including heart disease, depression, and substance abuse. Dr. Vincent Felitti, co-director of the study, noted that 'humans convert traumatic emotional experiences in childhood into organic disease later in life.' The higher the ACEs score, the greater the risk for chronic health problems. The ACEs study revealed that what happens to us (not what's wrong with us) shapes our health trajectories. This fundamentally challenges the idea that conditions like psychosis are primarily genetic brain diseases. If childhood experience has such a profound impact, then our approach to healing must address those experiences, not just suppress their expressions.

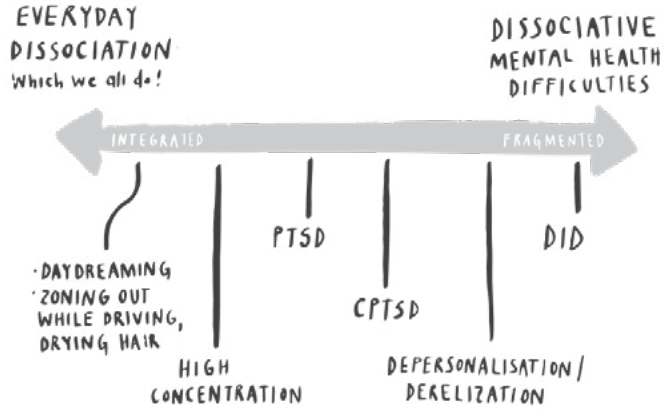
WHEN THE MIND FRAGMENTS: UNDERSTANDING DISSOCIATION AND PARTS

To understand how trauma connects to psychosis, we first need to understand how the mind protects itself when overwhelmed. This protection often takes the form of dissociation, and understanding dissociation opens the door to understanding both trauma responses and psychotic experiences.

The nature of dissociation

Dissociation refers to an altered state of consciousness characterized by a disconnection from one's thoughts, emotions, body, or surroundings. Dr. Bessel van der Kolk describes dissociation as a 'compartmentalization of experience', when people dissociate, they become divided from their own awareness and fail to fully integrate their experiences.

This isn't pathology. It's protection. Dissociative experiences exist on a wide spectrum. On the mild end, they include ordinary moments such as becoming absorbed in daydreams or losing track of time while driving. On the more extreme end, dissociation may manifest as depersonalization (feeling detached from one's body or self), derealization (feeling as if the surrounding world is unreal), or gaps in memory regarding traumatic events.



For trauma survivors, dissociation serves as an essential coping mechanism. It helps individuals distance themselves from emotional or physical pain that would otherwise be overwhelming. Dr. Stephen Porges, best known for developing Polyvagal Theory, explains that dissociation is not inherently negative but an adaptive survival response. The challenge arises when this response becomes chronic, leaving people disconnected from their emotions, relationships, and capacity to engage with daily life.

THE FREEZE RESPONSE: WHEN FIGHT AND FLIGHT AREN'T AVAILABLE

Dissociation is closely linked to the 'freeze' response outlined in Polyvagal Theory (which will be fully explored in part 2 of this book). When the body perceives an overwhelming threat and neither fight nor flight is possible,

the parasympathetic nervous system can trigger a freeze response, shutting down awareness of physical sensations and emotions. In such cases, the body becomes immobilized as a last-ditch effort to protect itself. This 'tonic immobility' is an ancient survival mechanism, more primitive than the fight-or-flight response. It's what happens when a young child faces abuse from a caregiver, there's nowhere to run, no way to fight back. The only option is to go away, check-out internally.

Here's what mainstream crisis response often misses: Everyone: client, family, and medical providers, wants to exit dissociation quickly because it feels frightening and looks like dysfunction. The tendency is to rush toward stabilization, to pull someone out of the shutdown state as fast as possible. However, this approach often leaves people stuck in survival mode, oscillating between hyperarousal and disconnection without ever moving through the deeper layers where true healing can occur.

PARTS: A UNIVERSAL HUMAN EXPERIENCE

It's essential to understand that having parts is completely normal. Every human has parts: younger versions of ourselves, protective voices, conflicting desires, different aspects that emerge in different contexts. You might have a part that wants to be social and another that craves solitude. A part that's ambitious and another that's terrified of failure. A part that trusts easily and another that's deeply suspicious. This is how consciousness works. Internal Family Systems (IFS) therapy, developed by Richard Schwartz and more in part two, recognizes this multiplicity as fundamental to human psychology. Our parts develop for good reasons, they help us navigate complex emotional terrain, protect us from pain, and hold different truths simultaneously. In healthy development, these parts remain relatively integrated, with a sense of 'Self' that can hold them all with compassion and curiosity. But when trauma occurs, especially during childhood, parts can become more distinct, more separated from one another. This is still adaptive: the psyche's way of containing what would otherwise be unbearable. Sarah had parts too. One part that believed her stepfather's narrative that

she was crazy and different. One part that held the terror and rage from the abuse. One part that tried to be normal and fit in at school. One part that carried her stepfather's voice, his words, his contempt. And one part that liked stepfather, because he had good sides, he used to bring her favorite soda in the weekend growing up, which was likable. These parts became more separated because integration would have meant facing the full reality of what was happening to her, something her developing mind couldn't bear while still living in that house, still dependent on adults who wouldn't protect her.

DISSOCIATIVE IDENTITY DISORDER: THE FAR END OF THE SPECTRUM

Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder, sits at the extreme end of the dissociation spectrum. It usually results from chronic, severe childhood trauma, often sexual abuse, physical torture, or ritual abuse that begins very young and continues for years. People with DID develop multiple distinct identities or alters, each with its own traits, behaviors, memories, and sometimes even their own voices and facial expressions. These alters aren't random, they serve specific functions. There might be a part that holds the trauma memories so the main personality can function in daily life. A part that's perpetually angry to protect against future violation. A child part that never got to just be a child. A part that believes the abuse was deserved, internalizing the perpetrator's voice. This is survival ingenuity, not madness. When a child experiences trauma so severe and so prolonged that their developing sense of self cannot integrate it, the psyche does something extraordinary: it creates separate containers for different experiences. This allows the child to continue functioning: to go to school, to appear 'normal', to survive, while the parts that hold the trauma remain hidden, sometimes even from the person themselves.

The confusion between DID and psychosis

Here's where things get complicated: because people with DID can experience alters that have their own beliefs and perceptions, they may display what looks like psychotic symptoms. Hearing internal voices. Experiencing reality shifts. Holding contradictory beliefs simultaneously. Feeling like they're being controlled by outside forces. For professionals unfamiliar with complex trauma, these experiences often get labeled as psychosis. The person ends up on antipsychotic medication that doesn't address the actual issue, which isn't a chemical imbalance but a fragmented response to unbearable circumstances. Sarah experienced a version of this. Her stepfather's voice wasn't technically an alter, but it was a dissociated memory so powerful it felt external. The line between 'intrusive traumatic memory' and 'auditory hallucination' can be razor thin. What matters isn't the precise diagnostic category, it's understanding what the experience represents and what it needs.

ANOTHER THOUGHT ON THE NEED FOR LABELS

One ongoing question in trauma and dissociation work is whether experiences like DID truly require diagnostic labeling. While a diagnosis can sometimes help structure treatment or offer language for what a person is going through, labels can also create a stronger identification with the diagnosis itself. Instead of feeling supported, people may begin to become the label, which can unintentionally limit their sense of possibility.

In therapy, something different happens — people begin to discover that having parts is completely normal, a universal human experience rather than a sign of pathology. The line between 'ordinary multiplicity' (which all humans have, including the therapist) and what we call a dissociative disorder becomes far less rigid. As clients learn to relate to their parts with curiosity and compassion, many find that the urgency

or necessity of a diagnostic label softens. What matters most is the client's own experience, needs, and reasons for wanting or not wanting a label. If a diagnosis helps someone make sense of their inner world, feel validated, or access care, it has value. If it restricts them, increases stigma, or reinforces a painful identity, then the therapeutic relationship and the work of integration can take precedence. Ultimately, healing begins not with labels, but with connection, safety, and the growing understanding that multiplicity lives within all of us.

PSYCHOSIS AS AN ADAPTIVE RESPONSE: A REVOLUTIONARY REFRAME

Now we come to the heart of the matter: What if psychosis itself is an adaptive response? Just as dissociation protects by creating distance from unbearable reality, psychotic experiences may serve similar protective functions, but through different mechanisms. Instead of disconnecting from reality, the person creates an alternative framework for making sense of what feels incomprehensible. Think about what psychotic experiences often contain:

- Voices that comment, criticize, or command
- Beliefs about being watched, persecuted, or controlled
- Intense meaning-making that connects seemingly unrelated events
- Heightened perception where everything feels significant
- Narratives that explain unbearable feelings of shame, fear, or worthlessness

When we explore these experiences with curiosity rather than dismissal, when we listen carefully and deeply, creating safety and connection — what initially sounds 'too crazy to be true' often reveals larger patterns that make profound sense. I've witnessed this repeatedly in my work: as trust builds and the person feels genuinely heard, more details

emerge. The fragmented story begins to show its logic. What seemed like random delusions connect to actual experiences of violation, betrayal, or terror. This is what happened with Sarah. At first, her symptoms looked like textbook first-episode psychosis. But as we created safety and I asked questions with genuine curiosity rather than diagnostic judgment, the larger narrative emerged: years of sexual abuse, psychological manipulation, systematic invalidation. Her 'psychotic' symptoms weren't malfunctions, they were her system trying to process and communicate what had been unbearable and unspeakable.

WHAT DIFFERENT EXPERIENCES MIGHT PROTECT AGAINST

Auditory hallucinations (hearing voices) frequently carry the tone, content, or actual words of past abusers. Like Sarah's stepfather's voice, these aren't random neurochemical misfires, they're traumatic memories that have become externalized. The voice saying 'you're worthless' or 'you deserve this' often echoes exactly what a perpetrator said during abuse.

For some, voices serve protective functions: warning about danger, offering companionship when isolation feels unbearable, or expressing anger that the person cannot safely express themselves. When we relate to voices with curiosity, asking what they're protecting against, what they need, what they're trying to communicate — we often discover they're parts of the person's own psyche trying to be heard.

Paranoid beliefs about being watched, followed, or persecuted may reflect a nervous system that learned, through painful experience, that the world is genuinely dangerous. For someone who experienced (childhood) abuse where they were constantly monitored, controlled, or punished unpredictably, hypervigilance isn't irrational, but learned survival. When that hypervigilance extends into beliefs about surveillance, conspiracy, or targeting, it may be the system's attempt to make sense of the constant sense of threat that trauma created. The belief 'I'm being watched' externalizes the internal

experience of never feeling safe, never being able to let one's guard down.

Grandiose delusions are beliefs about having special powers, divine purpose, or extraordinary importance, sometimes emerge as counterbalance to profound experiences of worthlessness or powerlessness. If someone's childhood was defined by helplessness, violation, and insignificance, the psyche might construct a narrative where they're actually powerful, chosen, significant. This isn't lying or attention-seeking; it's the mind trying to survive unbearable shame by creating an alternative truth.

Delusions of reference is the belief that random events have special meaning directed at the person, reflect the salience detection system running at high intensity. But this heightened meaning-making often has roots in trauma. When your survival once depended or still is depending on reading subtle cues from an abuser's mood, decoding what was safe and what was dangerous, your brain learned to assign profound significance to small details. That pattern doesn't just disappear when the danger ends.

THE SPIRITUAL EMERGENCY CONNECTION

For some people, what gets labeled as psychosis may actually be a spiritual emergence or crisis, consciousness expanding beyond its usual boundaries in ways that feel overwhelming and disorienting. Stanislav Grof, psychiatrist and consciousness researcher, distinguished between 'spiritual emergency' (a transformative crisis) and pathological psychosis.

The difference isn't always clear-cut. Both can involve:

- Dissolution of ordinary reality boundaries
- Profound meaning-making
- Experiences of unity or cosmic significance
- Encounters with archetypal figures or voices
- States of terror or ecstasy

What determines whether this becomes integrative or fragmenting often depends on the person's history (Do they have unresolved trauma?

Secure attachment? Support systems?) and the response they receive (Are they met with curiosity and containment, or fear and coercion?).

Trauma complicates spiritual emergence

Someone with a history of severe childhood abuse may experience consciousness expansion that triggers traumatic material they're not yet equipped to process. The spiritual opening becomes entangled with trauma activation, creating experiences that are genuinely both transformative potential and trauma response. When the boundaries of 'self' dissolve during spiritual emergence, unintegrated trauma can flood in, overwhelming the person's capacity to hold both the numinous and the horrific.

Spiritual emergence itself can be traumatizing.

Even for someone without significant trauma history, the experience of consciousness dissolving its usual boundaries can be terrifying. Encountering the numinous, facing ego death, experiencing cosmic dissolution — these aren't gentle processes. They can leave someone profoundly shaken, questioning everything they thought they knew about reality, struggling to integrate experiences that have no language in consensus reality. When spiritual emergence happens too fast, without adequate support or preparation, it can create its own trauma. The person may feel:

- Utterly alone with experiences no one else understands
- Afraid they're going insane
- Unable to trust their own perceptions
- Overwhelmed by energies or presences they can't control
- Terrified the experience will never end or will happen again unpredictably

This is especially true when the person's spiritual emergence is met with pathologizing responses, being told they're having a 'psychotic break,' being medicated into numbness, being treated as if their profound experience was merely brain malfunction. The invalidation itself becomes traumatic,

layering new wounds onto what might have been a transformative opening. This is where our either/or thinking fails. The question isn't 'Is this psychosis or spiritual emergence?' but rather 'What is this person's unique experience, and what does it need to move toward integration?' Someone may be experiencing genuine spiritual opening AND trauma activation AND neurochemical shifts that look like psychosis — all simultaneously. These aren't mutually exclusive categories. They're different lenses for understanding a complex human experience that defies simple categorization.

Why this reframing changes everything

When we understand psychotic experiences as potentially adaptive, as the nervous system's attempt to process the unbearable, to protect against overwhelm, to make meaning from chaos, treatment looks entirely different. Instead of just suppressing symptoms with medication, we ask: What is this experience trying to communicate? What does this person need to feel safe enough to integrate what they've lived through?

This doesn't mean medication is never helpful. Sometimes the intensity needs to be turned down before integration work can happen. But medication alone, without addressing the underlying trauma and meaning, leaves people managing symptoms rather than truly healing.

Building on Dr. Stephen Porges' insight that *there is no bad reaction, only adaptive responses*, we can begin to look at psychotic symptoms with the same compassionate curiosity we bring to dissociation. Both represent the system doing exactly what it knows how to do: survive. The shame many people feel about psychotic experiences, the sense that they're broken, crazy, fundamentally flawed — begins to shift when they understand their experiences as adaptive. You're not malfunctioning. Your system is responding to information, trying to protect you, attempting to make sense of what couldn't be borne. This is the heart of trauma-informed care: meeting people with empathy, grounding, and curiosity, and honoring the ways their nervous system has tried to protect them until they were no longer alone with the pain.

WHEN 'CRAZY' IS THE GOAL: GASLIGHTING, MIND CONTROL, AND FALSE MEMORY

There's another layer to this that demands attention, particularly for those who've experienced severe, organized abuse: sometimes being labeled 'crazy' isn't an unfortunate misdiagnosis: it's the intended outcome.

The strategy of invalidation

Perpetrators of severe abuse (including those with narcissistic, antisocial, or psychopathic traits) often understand dissociation and memory better than many clinicians. They know that:

- Extreme trauma fragments memory
- Dissociation creates amnesia
- Children can be conditioned to doubt their own perceptions
- If someone can be made to believe they're crazy, they won't be believed if they disclose

This isn't accidental, but it's a strategy. Many survivors recognize these perpetrator patterns:

Narcissistic abusers often employ:

- Reality distortion: insisting their version of events is the only truth
- Projection: accusing you of the exact behaviors they exhibit
- Triangulation: using others to validate their narrative and isolate you
- Love-bombing followed by devaluation that creates cognitive dissonance
- Making you doubt your own perceptions, memories, and sanity
- Positioning themselves as the victim when confronted
- Appearing charming and credible to outsiders while being cruel in private

Antisocial/psychopathic abusers may demonstrate:

- Calculated manipulation without remorse or empathy

- Charm and charisma used to gain trust before exploitation
- Systematic isolation from support systems
- Pleasure in others' pain or confusion (sadistic enjoyment of destabilization)
- No genuine emotional connection despite convincing performance of emotion
- Using your trauma responses as "proof" you're unstable
- Weaponizing the mental health system against you
- Deliberate creation of situations designed to make you appear mentally ill

Common gaslighting tactics across these patterns include:

- 'That never happened' (denying events you clearly remember)
- 'You're too sensitive / crazy / dramatic' (pathologizing your normal reactions to abnormal treatment)
- 'Everyone else thinks you're the problem' (false consensus to make you doubt yourself)
- 'You're remembering wrong' (rewriting history repeatedly)
- Subtle shifts in their story over time that make you question your memory
- Using your mental health struggles or diagnoses as weapons ('See? You ARE crazy')
- Telling others you're unstable while privately creating the instability

Sarah's stepfather used all of these. He called her 'different' and 'disturbed' when she was still a young child, before the sexual abuse even began, laying groundwork. He isolated her through shame. When she tried to tell the neighbor, he'd already established himself as a 'nice man' dealing patiently with a 'difficult' child. He used her normal trauma responses: fear, confusion, dissociation as evidence she was mentally ill. By the time she was a teenager, Sarah believed it completely. She was crazy. She was the problem. Gaslighting, making someone question their own reality, memory,

and sanity, is a fundamental tool of these abusers. When combined with systematic trauma that induces dissociation, it creates a perfect trap: the person fragments from the trauma, struggles to access coherent memories, and when they do remember, they've been so thoroughly conditioned to doubt themselves that they can't trust what they know. For survivors of organized abuse, ritual abuse, or prolonged narcissistic/psychopathic abuse, this often manifests as:

- Fragmented memories that feel unreal
- Fear that they're making it up or going crazy
- Internal voices (often internalized abuser voices) telling them it didn't happen
- Shame so profound that they can't speak about their experiences
- Actual diagnosis of psychosis when they try to get help
- Being labeled as having borderline personality disorder, bipolar disorder, or schizophrenia when their symptoms are actually complex trauma responses

The deliberate creation of 'crazy': Some perpetrators, particularly in organized abuse contexts, actively work to ensure their victims will appear mentally ill if they disclose. This can include:

- Deliberately inducing dissociative states during abuse
- Using drugs or techniques to create memory gaps
- Incorporating bizarre or ritualistic elements designed to sound unbelievable
- Coaching the victim to doubt their own experiences
- Creating 'cover memories' or false explanations for trauma symptoms
- Ensuring abuse happens in states (drugged, dissociated, very young) where memory will be fragmented
- Threatening that no one will believe them because they're 'crazy'
- Setting up situations where the victim's attempts to get help will look like delusions or attention-seeking

This isn't paranoid thinking, but documented perpetrator behavior,

particularly in cases of organized exploitation and ritual abuse (Salter, 2012; Becker et al., 2013; Miller, 2012). Research on complex trauma and organized abuse demonstrates that perpetrators often employ sophisticated psychological techniques specifically designed to discredit victims and fragment their sense of reality (Herman, 2015).

END TRIMMED EXCERPT CHAPTER 4

CHAPTER 9

WAYFINDING: LEARNING TO NAVIGATE YOUR STATES

'If you can read the ocean, you will never be lost.'
— Mau Piailug, Master Navigator

In traditional Polynesian culture, master navigators could sail thousands of miles across the open ocean without instruments, guided only by waves, stars, birds, and an internal compass developed over decades of practice. They learned to read the subtlest signs: how swells moved differently over shallow reefs, which birds flew at what time of day, how the color of water shifted near land.

THE ART OF NAVIGATION

These navigators understood something crucial: you can't control the ocean, the weather, or the currents. But you can learn to read the signs, understand the patterns, and navigate skillfully even through storms. When you're in crisis, moving through altered states, or navigating the aftermath of spiritual emergency, your usual compass fails. The internal compass you relied on has gone offline. The familiar landmarks have disappeared. You're disoriented in a way that feels terrifying because you don't know where you are or how to find your way back. This chapter is about learning a new kind of navigation. Not the kind that gets you back to 'normal' (that old normal might not be where you want to go anyway), but the kind that helps you understand where you are, what state you're in, and how to move toward safety and groundedness with choice and awareness.

THE POLYVAGAL REVOLUTION: A MAP OF YOUR NERVOUS SYSTEM

Before we explore how to navigate your states, you need a map. For decades, Western medicine thought the autonomic nervous system had two branches: *sympathetic* (fight-or-flight) and *parasympathetic* (rest-and-digest). Simple. Like an on-off switch. Then neuroscientist Stephen Porges changed this idea. In the 1990s, while researching how premature infants regulate their heart rate and breathing, he noticed something that didn't fit the two-branch model. Some infants, when stressed, didn't just activate their sympathetic system (heart racing, agitation). They did the opposite: their heart rate dropped, they became very still, and they seemed to shut down entirely. This shutdown response couldn't be explained by the sympathetic/parasympathetic binary. It looked like a parasympathetic response (slowing down), but it was happening during extreme stress, not safety. Something was missing from the model. Porges began investigating evolutionary biology, looking at how different vertebrates respond to threats.

What he discovered involved the *vagus nerve.* This is the longest cranial nerve in your body, wandering from the brainstem through the face, throat, heart, lungs, and deep into your digestive system. About 80% of its fibers carry information up from body to the brain. Your body is constantly telling your brain about its *state of being*. But here's what Porges discovered: the vagus nerve isn't one system. It's two distinct systems that evolved at different times and do completely different things. Combined with the sympathetic nervous system, this gives us three states — and understanding them changes everything about how we navigate crisis. In 1994, Porges published the polyvagal theory, which fundamentally shifted how we understand trauma, safety, connection, and altered states (Porges, 2011).

THREE STATES: MAPPING YOUR EXPERIENCE

Think of these states like *water* in different forms. It's the same substance but has radically unique properties.

I.
Ice: The Dorsal Vagal Complex (shutdown, freeze), red

The dorsal vagal system is the oldest part of the human nervous system. It evolved in ancient vertebrates, long before mammals existed, and is designed to respond when a threat feels inescapable and neither fight nor flight is possible.

Key features

- When it evolved: In ancient vertebrates, before mammals
- Location: The dorsal (back) part of the brainstem
- What it connects to: Organs below the diaphragm, primarily the stomach and intestines
- Survival strategy: Shutdown, immobilization, conservation of energy
- What it is designed for: Playing dead when escape is not possible

When this system activates, the body moves into a state of shutdown. A commonly used example is a gazelle caught by a lion: when escape is no longer possible, the animal goes limp, numbs to pain, and sometimes the predator loses interest. This same biological mechanism operates in humans.

Dorsal vagal activation can be experienced as freezing, collapsing, dissociating, or feeling profoundly heavy and disconnected from the body. Time may feel slowed, stretched, or as if it has stopped altogether. Some people describe watching themselves from far away, with a sense that nothing really matters.

There are often clear physical signs. Posture may slump. Breathing becomes very shallow. Hands and feet can feel cold. The voice may go flat or barely audible. Eye contact becomes difficult. Digestive processes slow down or shut down entirely.

Cognitively, thinking becomes less accessible and clarity drops. Movement can feel impossible, even when part of you wants to respond. This is not laziness or depression in a clinical sense, but an automatic and evolutionarily conserved survival response. The nervous system has determined that disappearance and immobilization offer the greatest chance of survival.

This state can also function as a gateway to deep physiological rest. When approached consciously and with sufficient safety and support, dorsal vagal activation allows for safe immobilization, surrender, and the conditions necessary for integration and healing.

II.
Steam: The Sympathetic Nervous System (mobilization, fight-flight), amber

The sympathetic nervous system represents a later stage of nervous system evolution. It emerged in early vertebrates, before the ventral vagal system developed, and is designed to mobilize the body for action in the presence of danger.

Key features

- When it evolved: In early vertebrates, before the ventral vagal system
- Location: Thoracolumbar spine
- What it connects to: Throughout the body, preparing organs and muscles for action
- Survival strategy: Mobilization, fight or flight
- What it is designed for: Active defense or escape

This is the system most people are most familiar with. When danger is sensed, whether real or perceived, the sympathetic system activates automatically. Heart rate increases. Muscles tense. Pupils dilate. Blood flow shifts toward the limbs. The body prepares to fight the threat or run from it.

Sympathetic activation is often experienced as anxiety, agitation, restlessness, anger, or a strong urge to move. The mind becomes fast and busy; thoughts race, and attention scans constantly for threats. You may notice tight shoulders, a clenched jaw or fists, shallow and rapid breathing, sweating, and an inability to sit still.

In more sustained activation, everything begins to feel like a threat. Hypervigilance sets in. Irritability increases. People may snap at others or feel constantly on edge. Rest becomes difficult or impossible. Although this

state can feel like energy or productivity, it is driven by survival rather than choice.

The fawn response also operates within this system. People-pleasing, over-functioning, performing, and exhausting oneself to remain acceptable are forms of sympathetic mobilization. Many people with psychotic sensitivity live in this state for years before crisis — constantly activated, rarely settling, never fully resting.

Over time, this level of activation is exhausting and unsustainable. The system remains in motion, surviving rather than living, doing rather than being, without access to deeper regulation or presence.

III.
Water: The Ventral Vagal Complex (social engagement, presence), green

The ventral vagal system is the newest part of the human nervous system and is uniquely mammalian. It evolved relatively recently in evolutionary terms to support safety through relationships and connection.

Key features

- When it evolved: In mammals, relatively recently
- Location: The ventral (front) part of the brainstem
- What it connects to: Above the diaphragm — face, throat, middle ear, heart, and lungs
- Survival strategy: Social engagement, connection, co-regulation
- What it is designed for: Safety through relationships

When this system is active, you are grounded and present. You are *able* to respond rather than react. Sensations, emotions, and thoughts can be experienced without becoming overwhelming. There is a sense of connection to your body and to others, and time feels appropriately paced rather than rushed or frozen.

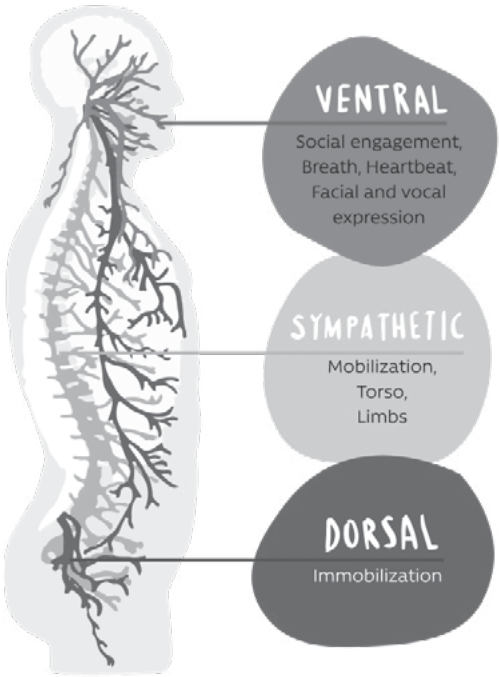
This system reflects a distinctly mammalian adaptation. Unlike reptiles, mammalian infants require prolonged care. As a result, humans evolved a nervous system pathway in which safety is created through proximity,

attunement, and relationship rather than through isolation or defense.

Physiologically, ventral vagal activation is associated with relaxed muscles, a calm and steady heartbeat, and easy, deeper breathing. The face becomes expressive. The voice carries melody and rhythm. Eye contact is possible. There is often a sense of warmth in the chest, and digestion functions smoothly.

Psychologically and emotionally, this state supports clarity of thought, curiosity, creativity, and compassion. There is access to a sense of inner center, often experienced in or around the heart. Connection feels genuine and in flow rather than effortful. Interaction does not require performance, pleasing, or vigilance.

This is the state in which attunement, intimacy, and authentic connection become possible; with oneself and with others — through openness, responsiveness, and presence.



WHY THIS IS CRUCIAL FOR UNDERSTANDING ALTERED STATES, INCLUDING PSYCHOSIS

Here's what makes polyvagal theory essential for understanding your experience: your nervous system is constantly scanning for cues of safety or danger, and it responds automatically, beneath conscious awareness. Porges calls this process *neuroception*, the unconscious detection of safety or threat. It's happening all the time, in every moment. Your nervous system is wondering: 'Am I safe? Am I in danger? Is this life-threatening?'

This isn't conscious perception. You don't *decide* 'I think I'm safe now.' Your nervous system detects safety or danger before you can think of this in full awareness through:

- Facial expressions of people around you
- Tone of voice (prosody)
- Body postures and movements
- Environmental cues (light, sound, space)
- Internal body sensations
- Past associations and memories

Based on what your neuroception detects, your nervous system shifts automatically. Safety activates ventral vagal: you can connect, think clearly, be present. Danger activates the sympathetic nervous system: you mobilize, fight, flee, become hypervigilant, fawn. Life threat activates dorsal vagal: you shut down, freeze, dissociate.

During a psychotic episode, spiritual emergency, or extreme altered states, your neuroception is often firing constantly, detecting threats everywhere. Even in objectively safe situations, your nervous system might be screaming 'DANGER!' Your system cycles rapidly between sympathetic activation (anxiety, racing thoughts, panic) and dorsal shutdown (dissociation, numbness, collapse). Sometimes you're in both simultaneously, what Porges calls 'dorsal vagal with sympathetic overlay,' frozen but wired at the same time. The behaviors that mental health systems label as 'symptoms' are intelligent nervous system responses to perceived threat:

- Pacing, rocking, unable to sit still → Sympathetic mobilization seeking discharge
- Freezing, staring, unreachable → Dorsal vagal shutdown
- Rapid speech, pressured thoughts → Sympathetic activation
- Flat affect, monotone voice → Dorsal vagal dampening
- Social withdrawal → Neuroception detecting others as threatening

If you are seeing images or patterns that feel meaningful, your neuroception may be detecting safety if they feel supportive or reassuring, or danger if they feel threatening or hostile. Your nervous system responds accordingly. If you are hearing voices that are critical or threatening, your nervous system detects danger even though others cannot hear these voices. In response, your sympathetic (amber) or dorsal (red) system activates, and your body reacts.

To an outside observer who cannot hear these voices or perceive these cues, your response may appear 'crazy.' However, your nervous system is doing exactly what it is designed to do: responding to a detected threat.

Similarly, if facial expressions or tones of voice around you feel threatening, even when they are objectively neutral, your neuroception is picking up cues that your system interprets as danger. This does not mean you are imagining the response. Your nervous system is detecting something. It may be detecting an actual threat, or it may be detecting through a threat-based filter shaped by your current state.

In either case, the body responds appropriately to what it detects. These reactions are not abnormal; they are normal responses to a different set of cues.

END TRIMMED EXCERPT CHAPTER 9

CHAPTER 11

CONNECTION: THE RELATIONAL FIELD THAT HEALS

'Attention taken to its highest degree is the same thing as prayer. It presupposes faith and love. Absolutely unmixed attention is prayer.'

— Simone Weil

In Chapter 9, you learned to recognize your nervous system states. In Chapter 10, you learned practices to ground to stabilize yourself. These are essential foundations. But here's what's missing from most mental healthcare: the recognition that healing happens in relationship. Through the lens of mutual healing, we view the therapeutic relationship, and indeed all healing relationships, as dynamic and collaborative spaces where both people are contributors to the healing process. This mutual exchange deepens trust and facilitates healing, where vulnerability and compassion guide the way forward. Healing is not a solitary path but a shared experience, one where both individuals hold space for each other and grow together.

SACRED PRESENCE: TWO LEVELS OF ATTENTION

Sacred presence operates on two levels. Embodied presence connects to the physical body, and the *seen world*, the grounded attention that allows us to truly be with another person in their suffering. Through somatic practices like yoga, breathwork, meditation, and mantra, we cultivate this embodied presence, calming the nervous system and inviting relaxation.

An energetic presence bridges us to the *unseen realms*, the subtle forces of the divine, ancestors, and wisdom that transcends the material world. By deepening our connection to the unseen through prayer, contemplation, or simply opening to what is larger than ourselves, we access guiding forces beyond the material. Both forms of presence are necessary. Without embodied presence, we float in abstraction. Without an energetic presence, we

become merely mechanical. Together, they create the field in which healing becomes possible.

You can practice all the grounding techniques in the world, but if you're surrounded by people who don't see you, don't understand you, or actively harm you, those practices will only take you so far. Conversely, when you're held by safe, attuned relationships, healing happens at a pace and depth that solitary practice cannot match.

WHAT'S MISSING IN MENTAL HEALTHCARE

The traditional psychiatric model is built on a fundamental power imbalance. The doctor is the expert. The patient is the problem. Treatment happens to you, not *with* you.

In this model:

- You're diagnosed, not enough listened to
- Your symptoms are managed, not understood
- Your compliance is monitored, not your wisdom honored
- Your relationships are rarely considered central to treatment

Even in therapy, which should be relational by nature, the frame is often: 'Here's a person with problems. Let's fix the person.' Not: 'Here's a person in a web of relationships, many of which may be harmful, unsupportive, or simply not attuned to their needs. What is going on in this system dynamic?'

LOST CONNECTIONS: THE SOCIAL DIMENSION OF PSYCHOTIC EXPERIENCES

The relationship between psychosis and social disconnection reveals one of the most profound aspects of these experiences. Research consistently shows that 75-94% of people with a psychotic diagnosis experience significant loneliness (Michalska da Rocha et al., 2018), far exceeding rates in the general population. These numbers represent real people navigating psychotic experiences while feeling profoundly alone.

Loneliness isn't simply a consequence of psychosis; it's both a risk factor and a maintaining factor. Studies show that social isolation often precedes psychosis onset (Gayer-Anderson & Morgan, 2013), while experimental research shows that induced loneliness directly increases paranoid thoughts in healthy individuals (Freeman et al., 2016). This creates a vicious cycle where isolation breeds suspicion, which deepens isolation further.

The pain of loneliness

The mechanisms are both psychological and neurobiological. Social exclusion activates the same pain regions in the brain as physical injury, while chronic loneliness triggers inflammatory responses that may contribute to psychotic symptoms. Understanding this bidirectional relationship opens new avenues for intervention: addressing social connection may be as important as targeting symptoms directly. Marginalization runs even deeper. Major social risk factors for psychosis include vulnerability to discrimination, migration, and childhood adversities. These experiences of exclusion shape how people relate to life itself.

In my practice, I've witnessed how psychotic vulnerability and other altered states can create profound isolation. People describe feeling like they're living behind glass, watching a world they can no longer fully take part of. Very sensitive. Also, the fear of being misunderstood creates protective withdrawal that paradoxically intensifies symptoms. Most heartbreaking is how loneliness becomes self-reinforcing. Protective parts (more about tis in the next chapter where I will speak about Internal Family Systems) that emerge to shield from rejection often guarantee it, a cruel irony that deepens suffering. Chronic marginalization doesn't just hurt emotionally; it alters how the brain processes information, particularly around threat detection and social safety.

Yet within this darkness lies hope. Understanding these connections opens healing pathways. When individuals experience secure and supportive connections, whether with family, community, or therapists — they nurture a sense of safety and belonging that promotes healing on physiological, emotional, and spiritual levels. The release of oxytocin, the bonding

hormone, becomes key in reducing the impact of loneliness and enhancing emotional resilience.

THE RELATIONAL MODEL

The relational approach flips the traditional model completely. In a relational model:

- Your experience is the starting point, not the thing to be overridden
- Healing happens through connection, not isolation
- The therapeutic relationship itself is the medicine, not just the vehicle for delivering techniques
- Your social context matters as much as your internal state

This isn't soft or secondary. Co-regulation, the nervous system synchrony that happens between people, is one of the most powerful healing forces available.

WHAT SAFETY REALLY MEANS

In Chapter 9, you learned about neuroception, your body's unconscious detection of safety or threat. This isn't something you can *think* your way into. Your nervous system decides, beneath conscious awareness, whether a person, place, or situation feels, or *is* safe.

True safety in a relationship means:

- Being seen without being fixed
- Being heard without being corrected
- Being met where you are, not where someone thinks you should be
- Having your experience validated, even when it doesn't make sense to the other
- Knowing the other person can handle your intensity without shutting down or taking over

Safety isn't the absence of distress. Safety is the presence of someone who can be with you in your distress without needing to change it, explain

it away, or make it about themselves. Most people who've experienced psychosis or altered states have also experienced profound relational rupture. People who used to see you suddenly see 'symptoms.' People who used to trust your perception now question everything you say. The psychiatric system, meant to help, often becomes another site of invalidation and coercion. Rebuilding safety takes time. It requires relationships where your nervous system can gradually learn: this person won't leave when things get hard. This person can handle my intensity. This person sees me, not just my diagnosis.

END TRIMMED EXCERPT CHAPTER 11

CHAPTER 15

CULTIVATING PRESENCE

'The success of Yoga does not lie in the ability to perform postures but in how it positively changes the way we live our life and our relationships.'

— T. Krishnamacharya

You've learned practices to ground yourself, how to work with your parts, how to navigate sensitivity, and how food and rhythm create the foundation for regulation. You've gathered frameworks from neuroscience, Internal Family Systems, and polyvagal theory. Now we go deeper into the ancient framework that shows how all these pieces fit together.

Before we begin, I want to say that what we're stepping into here is not just philosophy or technique, but a different way of seeing life itself. In many traditional cultures, including yoga, the world is understood as *animate* and relational. Mind, body, breath, memory, environment, and what we might call spirit are not separate domains but expressions of one living field. Healing happens through relationship, not isolation. Nothing exists alone. Even the word yoga comes from *'yuj'* — to yoke, to join, to connect — and it also means 'to be absorbed' into what you are relating with.

I love yoga for many reasons, but one stands out: it offers not just maps for understanding yourself, but actual tools for integration. This is what's so often missing. People read books, attend therapy, go to workshops, gain insight into their patterns — and then have no practices to help them live differently. Understanding without integration stays in the head.

And what we explore through a 'yoga lens' here are universal principles that work whether or not you ever use the word yoga. I'm not interested in the branded versions we see today. I'm interested in what's underneath: how patterns form, how we get stuck, how we change. These truths have been passed down through storytelling, myth, and lived experience — not as abstract doctrine but as wisdom you test against your own life.

AN ANCIENT MAP

This chapter offers an ancient map for working with experience, what we might today call *yogic psychology*, refined over millennia. If you're thinking, 'I don't know Sanskrit, I'm not into spiritual stuff, this isn't for me', stay with me. What you'll find here isn't foreign. It's a way of organizing what you already understand about thoughts, patterns, actions, consequences, and triggers into one coherent wheel. A framework for transformation that's been tested across centuries and transmitted through living lineages. This is dense material. I won't pretend otherwise. But its rich density, the kind that rewards your attention.

In this chapter, you'll learn:

- How states of mind and skills work together (you can't just decide to feel different; you must build the capacity to shift)
- The five-component wheel that keeps you stuck, and the multiple points where you can intervene
- Why sattva-dominant practice (calm, clear, pleasant, stable) is your benchmark for everything
- One-ness and ego-loss: The difference between controlled and uncontrolled ego dissolution: crucial for navigating altered states safely
- How to work with breath as a felt experience, not just mechanics
- Heart-centered practices that become your anchor

A LINEAGE OF PRACTICE, NOT BELIEF

This isn't generic yoga from a book or a studio class. This is Krishnamacharya → AG Mohan → me → you. Krishnamacharya (1888–1989) is often called the father of modern yoga; he taught many of the most influential yoga teachers of the twentieth century. He revolutionized yoga by adapting ancient practices for contemporary healing, emphasizing individualized approaches that meet each person where they are — a principle that runs through everything you'll learn here. This lineage integrates yoga with its sister science Ayurveda, distilled through my years as a psychiatric nurse and yoga therapist, offered now as a framework for your transformation.

Most important to me: I learned and taught to never *follow blindly*. We learn how to discern well, to think for ourselves. Don't take my words for 'truth.' That's why I offer wisdom that's survived thousands of years alongside modern science, but most importantly: your own experience. You must practice finding your own truth. I've added simple, accessible practices throughout this chapter — this is all you need. The framework gives you a map, but your practice gives you direct knowledge. Knowledge only becomes real through practice and integration.

ANCIENT SCRIPTURES

If we trace this way of seeing back to its roots, we arrive at the *Yoga Sutras (YS),* a small but essential collection of aphorisms in three parts, attributed to Patanjali:

- Chapter One, the Samādhi Pāda, speaks about steadiness: settling the turbulence of attention so you can be here. Not chasing, not resisting, but simply present.
- Chapter Two, the Sādhana Pāda, becomes practice: how to live in a way that supports clarity: how you move, breathe, act, relate, and care for your life. It is the ground. The daily tending of the fire.
- Chapter Three, the Vibhūti Pāda, moves into subtler terrain: what begins to unfold when attention becomes unified and steady. Perception refines. Boundaries soften. Sensitivity increases. You start to notice connections that were always there but previously unseen. The unusual capacities described here are not miracles, but natural expressions of deep attunement to life. They are not goals to pursue, but signs of intimacy with the field. Patanjali cautions: do not cling to them. Stay humble, relational, and grounded.

WHAT IS YOGA THERAPY?

Yoga therapy is the individualized use of yogic practices to support healing and well-being. Unlike group classes, it is offered one-to-one or in small

settings by therapists trained in trauma, nervous system regulation, and altered states. The focus is not on perfect postures, but on gently restoring connection with body, breath, and present-moment experience. For people navigating psychotic sensitivity or spiritual emergence, yoga therapy offers grounding, regulation, rhythm, and a way to meet sensitivity as capacity rather than pathology. At its core, it is a practice of meeting ourselves where we are, with kindness and curiosity.

WHY YOGA SUPPORTS PSYCHOTIC SENSITIVITY

When you're navigating psychotic sensitivity or spiritual emergence, you're often dealing with what Ayurveda calls: high *vata* — that quality of being too light, too mobile, too ungrounded. Your thoughts race. Your boundaries feel thin. You're hypersensitive to everything. You feel like you're floating away from your body. Yoga brings you back to earth. Literally. The physical practices ground excess vata through:

- **Weight and contact:** feeling your body's connection with the floor. Notice how your hands, your feet have grip with the earth.
- **Slow, intentional movement:** countering vata's erratic mobility with deliberate, grounded motion
- **Breath awareness:** anchoring your attention to something steady and always present
- **Rhythm and repetition**: creating the samskaras (positive grooves) that your nervous system craves

Yoga also helps regulate your nervous system. Gentle movement, especially when paired with breath awareness, activates ventral vagal pathways — the state of safety and connection. The slower, more grounded practices shift you from amber (sympathetic activation) to green (ventral vagal calm). And perhaps most importantly, yoga helps you return to your body repeatedly. When you've been dissociated, lost in your mind, or feeling like you're observing yourself from outside, the gentle invitation to feel your feet on the floor, to notice your breath, to sense which parts of your

body make contact with the earth — these simple practices rebuild the connection between awareness and embodiment.

END TRIMMED EXCERPT CHAPTER 15

CHAPTER 18

THE LIMINAL EDGE AND NATURAL LAWS OF HEALING

'If we throw mother nature out the window, she comes back in the door with a pitchfork.'

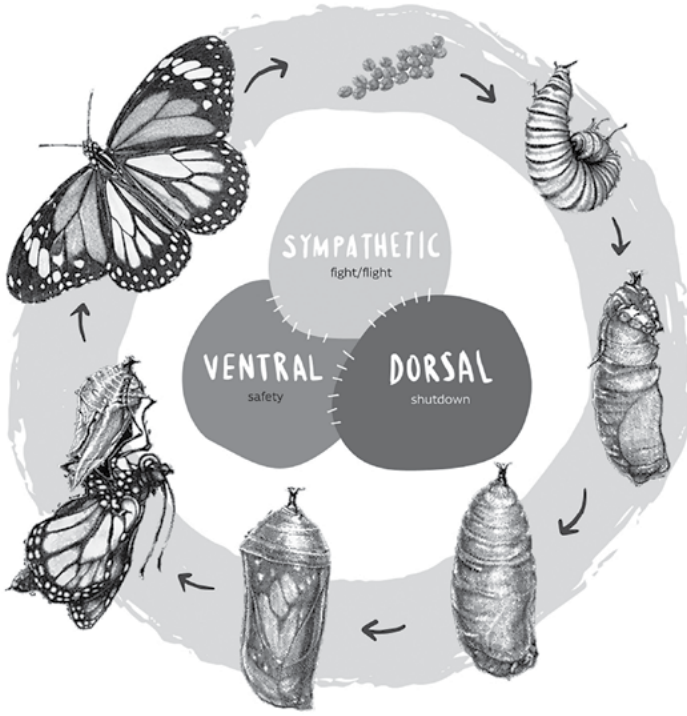
— Masanobu Fukuoka

In Chapter 9, you learned about the circular movement of nervous system states, including what I call the liminal edge, that deepest point in the cycle where something fundamental dissolves before something new can emerge. Not everyone travels to this edge, and not everyone needs to. But for those who find themselves here, whether through psychotic crisis, spiritual emergency, or profound loss, it's important to know this is a threshold that many have crossed.

THE LIMINAL EDGE: A THRESHOLD

The liminal edge is the space between what was and what's becoming. Chrysalis darkness. A *void* where the old self has died but the new self hasn't yet formed. This threshold exists not only individually but collectively. We are living in a liminal space too, right now, the old mental health systems are crumbling, their limitations and harms increasingly visible, while new paradigms are emerging but not yet fully formed. The old certainties about diagnosis, treatment, and recovery have dissolved for many, yet we don't yet have widespread alternatives that honor the full complexity of human experience. This *collective in-between* can feel disorienting, uncertain. But it's also generative, the space where genuine transformation becomes possible, where we can reimagine care entirely.

For individuals at the threshold, this territory requires specific support — someone who can hold steady while you dissolve, time for integration, and conditions that can hold dissolution without fragmentation.



Breath as anchor at the threshold

When you're at the liminal edge, when everything feels like it's dissolving, the breath becomes your most essential anchor. Not to control or force anything, but to maintain the thinnest thread of connection to your body, to the present moment, to the earth that holds you.

The practice is simple

Even when you can access nothing else, you can *notice* breath moving in and out. You don't need to change it. You don't need to make it deep or calm or perfect. Just notice it; the breath is happening. This body is breathing. I am still here — I am just here. Even after the inhale and after the exhale, where

there are moments of even non-breathing, the breath will catch up again. When dissolution feels complete, when you've lost all other ground, breath remains. It connects you to life even when you can't feel anything else. It's the bridge between the depths and the return.

If you're supporting someone at this edge, your regulated breath matters too. Breathing slowly and steadily in their presence, not forcing them to match you, just offering your nervous system's rhythm as a subtle anchor they can borrow from if they need it.

The liminal edge is *sacred territory*. It asks for patience, trust, and the willingness to not know. But it's not a place to stay permanently. It's a threshold to cross. And breath carries you through.

Ancient stories about the journey

Long before modern psychology named these experiences, wisdom traditions told stories about them. These weren't abstract theories but lived truths passed down through generations, maps for navigating the territory between death and rebirth.

In ancient Mesopotamia, they told the story of Inanna, the Queen of Heaven and Earth, who descended to the underworld. She goes because her sister has died, and something calls her down. At each gate, she must surrender something: her crown, her jewels, her royal garments, everything that made her who she thought she was. She arrives naked, stripped of all identity and power. And then she died. She remained dead for three days and three nights. This is not a story about mental illness, but a story about *transformation*.

When Inanna finally returns to the upper world, she's no longer the same goddess who descended. She now carries the underworld within her and knows death from the inside. She can hold both the light of heaven and the darkness of the depths. What looked like destruction was initiation.

Queen of the underworld

The Greeks told a similar story through Persephone, daughter of the harvest goddess, abducted to the realm of the dead. At first, this seems like pure

loss, a young woman stolen from sunlight and flowers, forced into darkness. But Persephone doesn't just survive the underworld. She becomes its queen. She learns to move between worlds, spending part of each year in darkness, part in light. Her descent brings winter. Her return brings spring. The seasons themselves are born from her cycling between realms.

What these stories understand (and modern psychiatry often forgets) is that descent serves a purpose. You don't descend because something is wrong with you. You descend because something in you knows that who you've been cannot hold who you're becoming. The old you, the performing you, the '*you*' that was built on others' expectations, it must die so your essential Self can emerge.

Maybe you can relate to this: during psychotic episodes, spiritual emergencies, or any profound crisis, everything that isn't essential begins to fall away. Not by malicious forces, but by the intelligence of transformation itself. The masks crack, the personas collapse, and the strategies you used to survive in the world stop working. You descend. This descent is not pathology. It's *katabasis* — the necessary journey down before you can return transformed. The hero must enter the underworld and face the darkness. The seed must fall into the earth before it can sprout.

Time and rhythm as a lifeline

The question is: will you have support to cross this threshold? Will someone understand that you're not broken but being broken open? Will you have practices to keep you anchored to earth while everything else dissolves? Will you have *time*, actual time, for the slow work of integration?

Because here's the other truth the myths teach: you can't rush the return. Persephone spends months in the underworld before spring comes. The seed gestates in darkness. The caterpillar dissolves completely before wings form. Inanna remains in death for three days, not three hours, not three minutes, before her rescue comes.

When everything else is dissolving, when you're at the liminal edge, dinacharya becomes your lifeline. The *daily rhythm* practices from Chapter

15: feet on the ground each morning, the same waking time, simple food at regular intervals, the mantra spoken even when all meaning seems lost — these aren't just helpful habits. They're how you stay connected to earth while navigating the darkness. The body remembers rhythm when the mind cannot. The earth holds you when you've lost all other ground.

END TRIMMED EXCERPT CHAPTER 18

END OF PREVIEW

WHAT IF THE EXPERIENCES PSYCHIATRY CALLS 'PSYCHOSIS' CARRY INTELLIGENCE?

When consciousness shifts through trauma, spiritual crisis, or states that move beyond diagnosis, many encounter fear, medication, and control. They're told their brain is broken, their perceptions cannot be trusted, and they need to be fixed.

This book offers a different lens: altered states are intelligible human responses to trauma and profound shifts in consciousness, calling for discernment and gentle care rather than suppression.

Wisdom of Psychosis weaves modern science with ancient maps of the mind to make complex experiences understandable and workable. Through clinical insight, embodied practices, and illuminating case studies, it offers orientation when inner worlds become overwhelming. It also brings a critical lens to both psychiatric reductionism and spiritual bypassing, holding sensitivity with depth, discernment, and dignity.

This is steady, practical guidance through three essential lenses: trauma recognition, spiritual honoring, and embodied integration, revealing the universal human layers beneath diagnosis.

For those navigating thresholds where worlds dissolve and remake themselves, and for those who walk beside them, this is a companion for the journey.

By Anneke Sips, RN

Anneke is a community psychiatric nurse, yoga therapist, and integrative trauma therapist with twenty-eight years of experience in crisis care and mental health. Trained in the Krishnamacharya yoga lineage, she pioneered the integration of yoga into psychiatric settings and has designed research interventions within clinical care. She has authored several articles and contributed book chapters on trauma, consciousness, and mental health; Wisdom of Psychosis is her first full-length book.

Her work bridges psychiatry and embodied healing, exploring the deeper layers of human consciousness through an integrative and relational lens. Known for her grounded presence and clarity, Anneke supports individuals, families, and professionals worldwide in learning to meet altered states and lived experience with steadiness, dignity, and discernment.

She lives on the Dutch coast with her daughter and two cats.