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Reducing global suffering and promoting long-term human flourishing through an in-depth understanding of emergent phenomena

Expert Consensus on the Intersection of Emergent Phenomena and Mental and Medical Conditions: A Delphi Pilot Study

This document presents the results from Emergence Benefactors' Expert Opinion Project Delphi pilot study whose aim was to develop preliminary guidelines for navigating emergent phenomenology in healthcare settings.

After three rounds of surveys and interviews, a final quantitative survey including 97 synthesised statements was administered to 22 experts, of whom 19 completed the round. 84/97 statements reached 75% agreement. Consensus was predefined as ≥ 75% of respondents rating a statement with "agree" or "strongly agree."

Contents

Glossary of key terms marked with an asterisk (*) can be accessed via the hyperlink here.

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Preliminary Clinical recommendations
Engagement
Clinicians should adopt a discerning, open, compassionate, and curious stance, employing active listening and cultural humility*, while maintaining clear therapeutic boundaries.
Clinicians can explicitly communicate that “nothing is unspeakable and everything is welcome” to establish psychological safety for disclosure of emergent phenomena*.
Clients/patients should be informed that while all is welcome, if an obvious safety issue (e.g., imminent risk to self or others*) is raised, the clinician has a duty to ensure their and others’ safety.
In healthcare systems with centralized medical records, clinicians should be transparent about documentation practices and potential long-term implications, as routine notes may remain accessible and affect future care, employment, or other life domains.
Maintaining an emotionally regulated, contextually attuned, and authentic presence when clients/patients share non-normative experiences is essential for ongoing therapeutic engagement.
First sessions should focus on exploring the client’s/patient’s experience through genuine curiosity and open-ended questions rather than providing advice or immediate solutions, unless grounding* support is required or significant safety concerns arise.
Clinical examination should use curious, collaborative inquiry focused on understanding meaning and assessing safety, rather than pathologizing language that can undermine outcomes.
To facilitate an effective therapeutic relationship, clinicians should use the client/patient’s preferred terms or concepts around emergent phenomena*, clarify meanings through open-ended exploration to establish shared understanding, and allow assessment to emerge from genuine engagement with the subjective narrative.

Clinicians should signal openness to emergent phenomena* in ways that honor diverse meaning-making frameworks without assuming clients/patients share particular spiritual, cultural, religious, or philosophical (e.g., ethical, epistemological, ontological) beliefs.
Before self-disclosure about personal experience with emergent phenomena*, clinicians should consider the client's/patient's trauma history, as such phenomena may arise from psychological, spiritual, religious, or trauma-based roots.
While precise language can aid clarity and validation, nonverbal communication may more immediately impact a client's sense of emotional safety; tone of voice (calm, warm, regulated), attuned (not intrusive) eye contact, and focused presence (undivided attention, grounded stillness) can signal attunement, respect, and nonjudgment—especially during disclosure of vulnerable or stigmatized experiences (e.g., emergent* or anomalous phenomena). **Caveat**: Sensitivity to context and individual needs is recommended, as some (e.g., neurodivergent individuals) may prioritize verbal precision over nonverbal cues.
Clinicians should inform individuals that emergent phenomena* can occur naturally and that some are relatively common; normalization and contextualization can alleviate transient distress and provide useful reassurance.
Assessment
Emergent phenomena* can coexist with signs and symptoms of clinical diagnoses (e.g., severe functional impairment*, severe distress*) in the same individual, challenging strict either/or labels.
Assessment and support should begin with the client/patient's subjective narrative as the foundation, recognizing its irreplaceable insights into meaning-making, distress, and transformation.
External perspectives (e.g., family, friends, community members) can help identify functional changes and risks the individual may not perceive or report.
Assessment and support should use transparent communication, seeking permission before introducing external observations and presenting them as additional perspectives rather than contradictions of the individual's narrative.
Practical clinical markers (including but not limited to severe distress*, severe functional impairment*, imminent risk to self or others*, preserved insight*) are necessary—though not always sufficient—tools for determining intervention intensity and support needs.

Such markers (e.g., severe distress*, sustained functional impairment*, preserved insight*) should be applied flexibly, with individualized assessment accounting for personal, cultural, and contextual factors and safety (e.g., imminent risk to self or others*).
Assessment of disruptions in consensus reality* testing (e.g., blurred boundaries between internal and external experience) should consider the intentionality and context in which they emerge (e.g., retreat/ceremonial context vs. a supermarket; following intensive emergent practice* vs. spontaneously).
While assessment should prioritize functional impact, distress, and safety rather than duration, low-risk phenomena that persist may be reasonably re-assessed to ensure duration has not heightened risk.
Clinical approaches (assessment, treatment) to emergent phenomena* should prioritize minimizing suffering and supporting wellbeing rather than categorization (e.g., diagnostic labels or qualifiers such as “non-ordinary,” “abnormal,” or “pathological”).
Some emergent experiences may temporarily increase distress and/or reduce functionality yet ultimately prove beneficial when appropriate support is available.
When documenting clients’/patients’ reported emergent phenomena, experiences and effects (EPEEs), clinicians should preserve the person’s own language alongside any necessary diagnostic documentation to maintain authenticity and potentially improve outcomes.
Emergent narratives should be approached with respectful yet discerning examination that identifies potential safety risks, especially where there is disconnection from consensus reality*, hallucinated commands, or beliefs that could lead to imminent risk to self or others*, or impaired judgment/impulse control.
While clinicians should remain vigilant for potential medical, mental health, and substance-related conditions when emergent phenomena* are reported, they should avoid premature medical diagnosis.
Clinicians should be aware that some emergent experiences are difficult or feel impossible to describe adequately in words.
When emergent phenomena* lack a cultural or conceptual framework, confusion or destabilization may occur; collaborative meaning-making—grounded in the client/patient’s values, background, and worldview—can aid organization, reflection, agency, and integration*.

Intergenerational trauma and cultural inequities may underlie emergent experiences and can contribute to therapeutic meaning-making.
Psychosocial and trauma assessments deserve at least equal emphasis as clinical assessments, given the possible psychological, spiritual, religious, or trauma-based roots of emergent phenomena*.
Diagnosis may be approached pragmatically (rather than as objective reality), incorporating cultural formulations and the client/patient's subjective meaning-making, while keeping focus on reducing suffering and supporting wellbeing and functioning.
For clients/patients seeking support in structured clinical settings (e.g., hospitals), basic health screening* might reasonably include medical history and basic laboratory work (e.g., CBC, basic metabolic panel, LFTs, thyroid panel, Vitamin B12) as a minimum standard.
Symptoms indicative of high-danger conditions (e.g., stroke, rupturing aneurysm, myocardial infarction, cerebral hemorrhage, encephalitis, poisoning, sepsis, severe electrolyte disturbances) should always prompt high suspicion and appropriate medical assessment.
Severe and/or persisting physical symptoms should trigger consideration of more in-depth medical evaluation or workup, regardless of the context of onset (e.g., retreat or ceremony).
Before attributing physical symptoms to emergent phenomena*, clinicians should rule out medical "red flags" (e.g., chest pain, neurological deficits, unstable vital signs).
Risk Assessment and Safety Planning
Stable social support, housing, wholesome diet, adequate rest, grounding* exercise, and insightful self-reflection are important protective factors that can reduce the need for hospitalization.
Strong supportive networks (family, friends, mentors, therapists) that understand emergent experiences as part of normal development improve the likelihood of safe outpatient care and should influence disposition decisions.
Involuntary social isolation generally increases risk of harm, though periods of voluntary solitude (e.g., retreats) may benefit some individuals.

Although more EP-specific research is needed, psychological flexibility, openness, emotion regulation capacity, tolerance of ambiguity, quality of social support, and access to support systems are considered helpful contributors to positive outcomes.
Spiritual, cultural, religious, philosophical (e.g., ethical, epistemological, ontological), and other meaning-making contexts can shape whether emergent phenomena* appear concerning; what is atypical in one framework may be expected in another.
Patient autonomy and the right to refuse treatment based on personal belief systems take precedence over clinician recommendations, except in cases of imminent risk to self or others*.
When urgent safety concerns (e.g., imminent risk to self or others*) necessitate protective intervention, collaborative approaches that actively involve the patient should be introduced promptly once immediate risks are addressed.
Acute Care
Imminent risk to self/others* should prompt emergency intervention and stabilization regardless of transformative context (e.g., emergent practice* or retreat).
Immediate safety concerns—such as risk to self/others* and inability to maintain basic functioning* (e.g., food, sleep, hydration)—outweigh diagnostic labels when determining level of care.
“Watchful waiting” (supportive observation) is an appropriate approach for many emergent phenomena* when there is no imminent risk, allowing time for natural resolution or integration with safety monitoring.
When protective intervention is required, preserving respect for the person’s subjective experiences whenever possible leads to better outcomes.
When medications are used in emergent phenomena* cases, they should target reduction of acute symptoms of severe distress* for stabilization, using minimum necessary dosing to ensure safety and functioning rather than complete elimination of experiences.
Stabilization via appropriate medication use can facilitate potentially beneficial therapeutic work (i.e., integration*) by reducing acute distress/destabilization (e.g., allowing sleep-deprived individuals to rest).
In certain situations, medications or hospitalization may disrupt meaningful growth and potentially positive transformative experiences; identifying such situations requires further research and careful development of guidelines and standards of care.

Medication decisions should focus on treating specific, clinically significant symptoms/distress (e.g., benzodiazepines for acute anxiety or insomnia) rather than long-term psychiatric medications intended to prevent recurrence of emergent experiences.
Clinicians should guide interventions that support natural healing and integration processes, avoiding pathologization while maintaining appropriate clinical discernment for safety.
Collaborative, relationship-based approaches should generally be tried before more structured frameworks (e.g., standardized protocols, checklists, algorithms, one-size-fits-all interventions).
Treatment decisions should respect the individual's current integration* capacity and natural timing in processing emergent experiences, avoiding rushed integration that could destabilize.
During acute distress, grounding* activities, calming techniques, and capacities that help maintain connection to consensus reality* (e.g., touching objects, sensory awareness) may be more beneficial than deeper integration* work.
Normalizing activities—skillful distraction (entertainment, humor), resuming recreational activities, socializing with non-emergence-focused friends, routine work, and simply "chilling out"—can be effective grounding* strategies, especially when practice-based interventions feel overstimulating.
A range of approaches can support people experiencing emergent phenomena*, including attention-based practices (e.g., mindfulness, guided imagery), somatic practices (e.g., breathwork, movement, sauna), and grounding* through social/physical reality.
Combinations of therapeutic approaches should be collaboratively sequenced with the patient, guided by the individual case, stage of integration*, readiness, and capacity.
Grounding* techniques can be prioritized for individuals in crisis or overwhelmed by internal focus, with additional techniques introduced gradually based on readiness and capacity.
Long-Term Care
Long-term treatment planning should occur only after initial stabilization of acute presentations and assessment of integration* capacity, as some approaches can be counterproductive if introduced too early.

Active facilitation techniques (e.g., hypnosis, guided imagery) to enhance integration* may be ethically appropriate when: **Competence** (specialized training), **Client state** (stabilized with adequate emotion regulation and functional capacity), **Consent** (explicit and informed), **Context** (established therapeutic relationship with appropriate set/setting/timing; not for crisis), and **Safety** (robust protocols and supports) are in place.
Healthcare providers should adapt treatment to honor clients'/patients' cultural worldviews and explanatory models, integrating these into care planning.
Key markers of healthy integration* capacity include curiosity about the experience, resilience with difficult emotions, maintained basic functioning* and hygiene, stable sleep–wake cycles, capacity for sustained attention and self-regulation, and willingness to seek support when needed.
When cultural interpretations appear to exacerbate harm (e.g., reinforce self-destructive behaviors), clinicians might collaboratively explore alternative interpretive frameworks, preferably from within the client's/patient's own tradition.
Decisions about reducing, modulating, or eliminating emergent phenomena* should respect client/patient autonomy whenever safely possible and involve evidence-informed discussion of risks, benefits, and alternatives across short-, medium-, and long-term horizons.
For individuals with addiction histories, treatment planning should consider whether underlying trauma may be driving both addiction and emergent phenomena*.
Supporting integration* and meaning-making around emergent experiences can positively shape long-term outcomes.
Adequate sleep, hydration, nutrition, and stress management can be important supports for integration* and emotional regulation.
Regular contemplative emergent practices* (e.g., meditation, prayer, contemplative reading, scripture study) can sometimes support long-term integration* when aligned with client/patient values.
Regular body-based emergent practices* (e.g., yoga, Qigong, martial arts, breathing techniques) can sometimes support long-term integration*.
Individualized combinations of approaches (e.g., grounding*, somatic practices, psychoeducation, spiritual/existential support) are often more effective than a single modality.

Non-pharmaceutical interventions (e.g., creative expression, art therapy, narrative therapy) may provide valuable processing opportunities.
Notwithstanding safety considerations, complications of emergent phenomena may reflect processes that—with supportive integration, skill development, and meaning-making—can eventually have beneficial aspects.
When emergent phenomena* extend beyond a clinician's expertise, clinicians should acknowledge limitations and use referral networks for specialized spiritual, contemplative, and/or healing traditions with established support frameworks.

Preliminary non-clinical recommendations
Professional Standards
To practice ethically and effectively with clients/patients experiencing emergent phenomena*, clinicians should develop awareness of and openness to diverse spiritual, cultural, religious, and philosophical (e.g., ethical, epistemological, ontological) frameworks and traditions.
All clinicians working with emergent phenomena* require a foundation of core therapeutic qualities (e.g., compassion, openness, humility).
Specialized knowledge of specific spiritual, cultural, religious, and philosophical frameworks enhances—but does not replace—the need for core therapeutic qualities in this work.
Specialization and Training
To improve recognition of and appropriate responses to emergent phenomena*, healthcare systems could implement specialized training programs that integrate academic knowledge, practical assessment tools, case studies, cultural considerations, and experiential learning.
Experiential components of specialized training (e.g., personal meditation practice) should be optional for basic training but required for advanced qualifications in emergent phenomena specialization.

Dual expertise across clinical and emergent practice* (e.g., a psychiatrist with personal experience in meditation, yoga, prayer, martial arts, psychedelics, etc.) is a valuable enhancement.
Practitioners working with emergent phenomena* and/or emergent practices* may benefit from guidance on when therapeutic work transitions into spiritual/religious teaching or mentoring and how to navigate these transitions ethically.
Where feasible, support personnel trained in emergent phenomena* should be available on-site or on-call at retreats and ceremonies where emergent phenomena are likely.
Substantial specialized knowledge of specific spiritual, cultural, religious, and philosophical frameworks becomes critical for clinicians who regularly work with emergence, practice in settings where emergent phenomena* are common (e.g., retreat centers, psychedelic-assisted therapy, intensive spiritual practices), or serve populations with specific backgrounds; in general practice, foundational therapeutic skills and strong referral networks may suffice.
Current diagnostic frameworks (DSM-5-TR, ICD-11) may aid professional communication and initial assessment but require systematic enhancement (e.g., cultural, philosophical, spiritual, moral, aesthetic, and other contextual dimensions) to avoid inadvertently pathologizing emergent phenomena*.
Professional development should emphasize building relationships and networks with interdisciplinary spiritual or community-based leaders (e.g., elders, shamans, healers, clergy, cultural educators) and practitioners for effective collaboration in integrative, culturally responsive care.
Healthcare System Integration
Healthcare systems could better serve patients/clients by recognizing that some experiences labeled pathological may represent normal developmental processes requiring skill development rather than medical treatment.
Meaningful integration of emergent phenomena* in healthcare may be achieved by expanding existing models to incorporate cultural, spiritual, and phenomenological perspectives, among others.
Peer-supported safe houses and respite centers supervised by licensed professionals (e.g., mental health professionals, nurses, social workers) with specialized training in emergent phenomena* could provide alternative pathways for long-term healing and integration*.