Visual Snow - A Spiritual Perspective

Editor's Note: I have had, and continue to have the visual snow phenomena experience my entire life. All spiritual teachers I have come in contact with, have all had the same phenomena with their vision as well. My current belief around this "visual snow" idea is a bit different than the article's description below, however the article does give the reader an accurate description of the experience. Essentially, this phenomena is related to something called the "Prime Radiant." The "Prime Radiant" is the concept where there is only 1 particle in all of existence. This one particle is THE God particle. This particle creates all of reality, and all the atoms, molecules, and forms which we see around us. This one God particle has no limitations in terms of speed or mass, and because of this unlimited speed, literally creates all of existence simultaneously, in a grand cosmic fractal math equation, which literally produces each of us, and all of reality from ground up. Those of us who are more aware than others, or more open to such concepts, or are on the verge of seeing auras or other dimensions through clairvoyance, are more likely to have this "visual snow" experience, and thus are literally seeing the God particle create reality right before our eyes. This is perhaps a bit more of an empowering perspective than there being "something wrong" with our vision. This is also one of the concepts integrated in my Trilogy, The 7th Journey. Think about it. Enjoy the article! -------------------

Visual snow is a transitory or persisting visual symptom where people see snow or television-like static in parts or whole of their their visual fields. According to the notion of hallucinatory form constants by Klüver (1942) and Siegel and Jarvik (1975), it can be conceived as a variety of visual hallucinations of random form dimension. As such, the phenomenon should not be confused with normal entoptic phenomena such as Haidinger's brush, which almost never have sufficient intensity to gain clinical significance as a source of suffering or functional impairment. Visual snow, like all other forms of visual hallucinations, is non-specific as regards etiology (cause of illness). Therefore, each subject with a leading complaint of visual snow needs a full diagnostic work-up including ophthalmologic, neurological and psychiatric examinations as well as CAT or MRI scans of the brain. Visual snow
can occur in a variety of ophthalmologic disorders that can be diagnosed by the presence of additional clinical signs and symptoms. Persisting visual snow can feature as a leading symptom of a migraine complication called persistent aura without infarction (International Headache Society, 2004), first described by Haas (1982) under the designation prolonged migraine aura status. It is important to keep in mind that there exist many clinical subforms of migraine where headache may be absent and where the migraine aura may not take the typical form of the zigzagged fortification spectrum, but manifests with a large variety of focal neurological symptoms, so that the condition is commonly under diagnosed. Another frequent cause of visual snow is Hallucinogen Persisting Perception Disorder (HPPD) following use of LSD, MDMA (ecstasy), psychedelic mushrooms or other hallucinogens. In HPPD, the symptom of visual snow has been described by Abraham (1983) as aeropsia (literally "seeing the air"). It is noteworthy that HPPD can occur after a single dose of a hallucinogen and with a considerable latency between last drug intake and onset of persistent perception disorder, so taking a thorough life-time drug history is mandatory in the diagnostic-work up of visual snow. There exists anecdotal evidence from single case observations that a variety of other illegal or prescribed drugs including cannabis, antibiotics, anti-depressants and neuroleptics may cause visual snow or other symptoms of persisting perceptual disorder, but for the time being this has not been established for any of these aforementioned classes of drugs. Moreover, a variety of illnesses (e.g. Lyme disease, auto-immune disease) or nocious events (e.g. prolonged use of a VDU, dehydration, over-acidification) have been blamed by sufferers in self-help internet forums as causes of persisting visual snow, but none of these claims have been supported by evidence-based medicine. Some patients fail to find any apparent causative illness or event in their lives, instead saying the snow came out of nowhere or has been with them for their whole life. It has been suggested by Jäger et al. (2005) that such cases of "primary persistent visual disturbance (visual snow phenomenon)" may possibly represent a variant phenotype of persistent aura without infarction. In addition to visual snow, patients suffering from persistent perception disorder frequently have other types of visual disturbances such as starbursts, increased afterimages, trails, palinopsia and many others (Podoll et al., 2006). Non-visual symptoms such as tinnitus or depersonalisation-derealisation are also frequently encountered. All of these additional symptoms have been described as manifestations of both migraine aura and HPPD, emphasizing the major importance of these two diagnoses for an explanation of the visual snow condition. Secondary psychiatric sequelae such as anxiety, panic attacks or depression may develop and necessitate appropriate treatment. There currently is no established treatment for visual snow. In HPPD, clonazepam has been recommended as medication of first choice in patients seeking medical help (Lerner et al., 2001). Furthermore, drug abstinence is of major therapeutic importance in HPPD. In persistent aura without infarction, the evidence so far suggests that acetazolamide may be the premier drug for patients with the repetitive form of aura status (Haan et al., 2000) and that valproate (Rothrock, 1997), lamotrigine (Chen et al., 2001), or topiramate (Podoll et al., 2005) should be first choices for patients with the continuous form. When these oral drugs are ineffective, an intravenous injection or injections of furosemide should be tried (Rozen, 2002). However, with very little scientific research on the condition taking place, for the
time being the effectiveness of such treatments remains based solely on anecdotal evidence. Beyond pharmacological approaches, appropriate counselling and cognitive behavioral interventions that focus on coping with the condition may be of huge importance. Source