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Spirituality: A New Way into Understanding Psychosis

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11.1 Introduction

The acceptance-based therapies excel at recognising the truism that wherever you want to get to, you have to start from where you are. This assumes that we know where we are – not a safe assumption if you want to question the dominant paradigm and hence the generally received perception of where we, collectively, are. In order to grasp the relationship between psychosis and spirituality, it is necessary to question some cherished assumptions. There is little of interest to be said about that relationship when you start from the common assumption that psychosis is an illness, and a disastrous one at that, while spirituality is a good thing, possibly personally irrelevant, but which other people regard as positive. The spiritual and supernatural content of much psychotic preoccupation is just seen as pathological from this perspective. Most psychosis research is constrained by this assumption.

This constraint is achieved by ignoring a crucial element of the data: lived experience. Psychiatric diagnosis is undertaken by sampling specific data elements to fit a preordained classification system. Cognitive behaviour therapy (CBT) for psychosis privileges belief. For the person experiencing it, psychosis can plunge them into a different way of experiencing, taking them into strange, dreamlike territory and separating their reality from that of others. That separation is sometimes more insidious, more partial, but still lands them experientially in a different place. The richness of these data is lost where individual experience (as opposed to discrete answers to specific questions) is discounted.

What about spirituality? How do we know that something is 'spiritual'? The same ceremony or occasion can be labelled 'spiritual' by one person and leave

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another cold; a location or event – say a mountain or a meal – can be deemed sacred by some, and ordinary by others. Again, it is down to a quality of experience. No objective formula can capture that distinction.

11.2 Repositioning Psychosis and Spirituality: Recognition of the Two Ways of Knowing

I appeal to cognitive science to explain this phenomenon of two ways of experiencing, and have written much about it elsewhere (e.g. Clarke, 2005, 2008a, 2010), following Teasdale & Barnard's (1993) model of human cognition, Interacting Cognitive Subsystems (ICS). ICS explains this phenomenon as follows. Detailed cognitive experimentation suggests that the human mind works through different subsystems passing information from one to another and copying it in the process. In this way, each subsystem has its own memory. Different systems operate with different coding: verbal, visual, auditory, for instance. There are higher-order systems that translate these codings and integrate the information. The crucial feature of this model is that there are not one but two meaning-making systems at the apex. The verbally coded propositional subsystem gives us the analytically sophisticated individual that our culture has perhaps mistaken for the whole. However, the wealth of sensory information from the outside world, integrated with the body and its arousal system, is gathered together by the implicational subsystem, which looks after our relatedness, both with others and with ourselves. The implicational subsystem is on the lookout for information about threat and value in relation to the self – we are, after all, social primates, and where we stand at any one time in the social hierarchy is crucial to our well-being, if not – normally – our survival

We are unaware of this gap between our two main subsystems because they work seamlessly together most of the time, passing information between them, so that we can simultaneously take the emotional temperature and make an accurate estimate in any situation. This starts to break down in states of very high and very low arousal, whether in a state of high stress or in drifting and hypnagogic states. The application of certain spiritual disciplines, or certain substances, can effect this decoupling between the two subsystems in waking life, so affording a different quality of experience, where the sense of individuality becomes distorted or merged into the whole.

This phenomenon becomes comprehensible when we consider that the propositional subsystem filters our experience to make it manageable, and in doing so, removes immediacy and supernatural glow. It enables us to grasp boundaries between people and things and logical relationships. Without this filter we lose these useful aids to navigating normal life – but can gain a dimension of experience that people seek, whether through drugs, spiritual or other practice, art and so on.

This dimension of experience embraces both valued attributes such as originality and spirituality, and the feared state of madness. Loss of boundaries, which results in the mystic's unitive experience, also underpins the persecutory experiences of thought insertion and thought broadcast of psychosis, for instance.

In summary, the two types of experience arise from the limitations of our processing apparatus. We can either achieve certainty about a limited segment or apprehend the whole but without the means to really grasp it. Science, by concentrating on the objectively verifiable, is blind to the way of knowing that captures all that is really valuable to people: relationships both inner and outer. This is the way of knowing that embraces both psychosis and spirituality.

11.3 Research Basis

Not all science has deserted this field. Over the last 10 years or so research into 'anomalous experiencing', to give it a neutral label, has started to take off. Gordon Claridge's schizotypy research (Claridge, 1997) started from an interest in vulnerability to psychopathology, but moved into establishing openness to anomalous experiencing as a universal human dimension (Claridge, 2010). High schizotypy bestowed advantages such as high creativity and spiritual sensibility, as well as the obvious vulnerability.

Students of Claridge led a strand of research that took a fresh look at psychotic experience and directly juxtaposed it with spiritual or creative experience, with startling results (Chadwick, 1992, 2010; Jackson, 1997, 2010). This married with Peters *et al.* (1999), Peters (2010) looking at the significance of context for the impact of unusual beliefs and experiences. More recently, in the work of Brett *et al.* (2007), Brett (2010) and Heriot-Maitland *et al.* (2011), comparable experiences for people in different contexts (clinical or nonclinical) have been shown to result in significantly different life adaptation. Taken together with robust epidemiological findings (Warner, 1994), these data point to the uncomfortable conclusion that much routine health-service practice is producing iatrogenic harm. At the same time, the neuroscience underpinning these phenomena has been investigated in a way that respects the spiritual dimension (Lancaster, 2010; Simmonds-Moore, 2009).

11.4 Spirituality and Mental Health

To return to spirituality and attempt to pin down this elusive concept: the description of two distinct ways of knowing available to human beings places spirituality in the holistically apprehended category. It has recently become not merely acceptable but actually required to include consideration of spirituality within health care.

The British National Health Service has started to take this dimension seriously, and much has been written on this subject both by the Department of Health (e.g. Department of Health, 2009; National Institute for Mental Health in England *et al*., 2004) and by service user focused organisations such as the Mental Health Foundation (2006, 2007). These and other documents promote recognition of the importance of religion and spirituality within health care, and the need for staff to address this aspect of the individual with sensitivity within a holistic context, but without producing any clear definition of spirituality itself.

Acceptance and commitment therapy (ACT) has of course always recognised the importance of spirituality. In his paper 'Making Sense of Spirituality' (Hayes, 1984), Hayes locates the concept within a behavioural framework by equating it with 'you-as-perspective' (p. 104), the perspective which offers the possibility of the reflection and distance essential for the type of revision of stuck patterns sought in therapy that can be achieved through mindfulness. Hayes links this with the disruptive effects of speech and mystical spiritual traditions as follows:

> Mystical traditions are explicitly oriented toward enhancing the distinction between the verbally-held *content* in peoples' lives and the *context* of pure-perspective established in verbal organisms (p. 107).

I here propose to take this subjective knowing perspective one step further by introducing the similarly subjective experience of relationship. A sense of relationship with something (someone?) beyond, the widest and deepest, is commonly implied by spirituality and religion. This fits with a view of the human being that follows from an appreciation of the consequences of the split in human knowing. The self-contained, self-directed individual becomes only part of the story. When grounded in experiential knowing, we flow beyond individuality into relationship. Normal life is a constant intersection of the two. We make decisions and act on them. At the same time, we rely on our containing roles and relationships to define us. Sufficient rupture in these leads to breakdown (see Clarke, 2008b, pp. 118–124 for a fuller exposition of this view of the person). At times when these sustaining roles and relationships (including the internal relationship between the individual and themselves) desert or turn against us, the wider, deeper layer of relationship that many (but not all) recognise as spirituality becomes crucial, providing the meaning and coherence that enable us to carry on. This works well where we can hold on to our individuality while drawing on that wider context for sustenance. Accessing the wider dimension can aid the path of healing, constituting a transformative growth experience (Grof & Grof, 1991). Where this safe foothold is lost, however, we can become engulfed in the other way of knowing, losing our ability to function coherently with others in the world. This is a state of confusion – between inner and outer (as in voice hearing), between safety and danger (paranoia), to give but two examples. It is a state of openness and vulnerability, where the boundaries of individuality are loosened. Could it be a state in which influence

from beyond the individual might actually intrude? Other cultures, subcultures and religious traditions accept notions such as possession (Tobert, 2010) and disembodied communication. Are we so sure that these must be ruled out?

11.5 Clinical Approach: The Therapeutic Alliance

This perspective offers a more sympathetic and hopeful slant on psychosis, and one which can be invaluable in forming a therapeutic alliance. Any therapy for psychosis can only proceed once there is a therapeutic alliance based on the common aim of management of symptoms to the extent that the individual can function in the world.

There are well-attested barriers to achieving such an alliance. The stigma associated with a diagnosis such as schizophrenia in our society has a lot to answer for in this respect. This stigma can produce two distinct sources of avoidance. For some, the fear of symptoms, such as aversive voices, is so great that they are too frightened to focus on them in case they return or get worse, and are therefore resistant to talking about them or working on them (see Gumley & Schwannauer, 2006 for a development of this theme). Other individuals conclude, with some justification, that society has little to offer them, and so retreat into a psychotic world, which has many disadvantages, but at least offers more status and meaning, albeit illusory. Not taking prescribed medication and using psychoactive substances such as cannabis are readily available means of perpetuating this state. Persuading these two groups to engage in a programme of coping skills, which requires them to be prepared to face their symptoms and to join the shared world, is a challenge of acceptance, and is one that our programme is designed to address.

11.5.1 The What is Real and What is Not Approach

This is delivered in our acute service as a four-session group, held in the hospital, but open to people in crisis being supported by a home treatment team and to people who have recently been discharged from hospital. The same approach is used in individual work and has been adapted for a longer group to be delivered in the community or in longer-stay settings. The programme is offered to anyone who is prepared to identify themselves as having experiences that others do not share, irrespective of diagnosis. These might be voices or visions (hallucinations, flashbacks), strongly held beliefs (delusions) or fears (paranoia). In inviting people to join the group, a new way of looking at symptoms is offered, as well as coping strategies. The fact that someone is in hospital, suggesting that others do not share their viewpoint or are concerned about them, can be helpful in persuasion. Thus the interest of people who are otherwise alienated by the mental health system can sometimes be engaged.

11.5.2 Schizotypy and 'Unshared Reality'

This approach is characterised by treating participants as the interested and intelligent adults that they are, and so presenting (briefly) research findings behind the key ideas. The programme first introduces Romme & Escher's (1989) idea of normalising voice hearing and drawing on the coping resources of experiencers for mutual support, but extended to other unusual experiences, unshared beliefs and fears. We then invite participants to give examples of how their experiences might fit into this spectrum, but with no pressure to contribute. Lack of pressure is particularly important, as it is a short group for people at the acute stage. Attending and not saying a word is perfectly acceptable, but most people feel able to share once they have got to know the other participants.

We then introduce the idea of openness to voices and strange experiences – the schizotypy spectrum, highlighting Gordon Claridge's research effort at normalising openness to this other way of experiencing given the right conditions (drugs, trauma, sleep deprivation etc.), while recognising that some are more open than others. This offers a hopeful perspective, as the research identifies positives, such as creativity and spirituality, associated with high schizotypy – along with the greater vulnerability to psychotic breakdown.

The positive and the negative aspects of high schizotypy are discussed and the group comes up with examples of famous high schizotypes: artists such as Van Gogh or celebrities such as Stephen Fry. We then introduce the specific example of a high schizotype who used this to advantage in the singer David Bowie. Bowie surmounted his vulnerability and used his high schizotypy to great effect in his act, adopting varied strange personae, with a theme of being an alien from outer space (Buckley, 2001). This example provides an accessible role model of someone who was able to inhabit both 'realities', shared and unshared; to know which he was in at any one time; and to move from one to the other and so operate creatively in a way that communicated with and was effective in the wider world.

The rest of the group programme aims to provide strategies for managing openness to unshared reality and participating in the shared world, without necessarily totally rejecting the unshared. This contrasts with other mental-health programmes, which tend to aim at elimination of 'symptoms' (i.e. unshared experiences). It respects individual values, whether they reject unshared experiencing or see it as an integral part of identity, or stages in between. Where the individual sees what others label as 'psychosis' as their access to a valued spiritual reality, this approach opens a way to dialogue. Where linked to a faith, discussion with the chaplain or other faith representative can establish whether or not someone's interpretation is normative. However, spiritual and mystical experience has always led people into unique experience, producing new insights that can be seen as challenging or heretical by orthodoxy. We are here operating beyond the realms of certainty.

In this way, the aims of the group are presented as something that will give the participants more control, but without having to reject their unique experiences or to accept a stigmatising label. Medication is recognised as one of these possible means of control, and an important one, along with psychological coping strategies. The need to commit to monitoring, to noticing whether the group members are in shared or unshared reality, is presented as essential to following the programme at this point, and monitoring sheets are handed out to be filled in between sessions. Participants are also invited to identify a personal goal for the group. This is rated at the end on a visual analogue line and represents an ideographic evaluation tool (see Durrant *et al*., 2007, p. 123 for a description of how this is used).

11.5.3 From Conceptualisation to Coping Strategies

This conceptualisation both motivates the individual to want to cope with their symptoms and suggests priorities for doing so. The detailed programme is available in the full manual, which is downloadable from my website (www.isabelclarke.org). The first stage is to accept that some perceptions and experiences are unshared – discrepant from the norm – and therefore should not be uncritically trusted; but it often requires courage to face this. The next stage is to learn to distinguish which reality you are in at a given time. This is established by exploring the difference between the two sorts of experience through discussion in the group. People usually recognise that a sense of importance, of meaning and the supernatural, goes with the 'unshared' side. This can feel very frightening, very isolating or very grand and wonderful. Sometimes everything seems to come together – or to fall apart and be meaningless. It can be hard to know who you are: important or worthless. Every group identifies that unshared reality is buzzy and exciting, while ordinary reality is flat and boring, which explains some people's preference for the unshared.

Once someone has got their bearings, coping strategies to help them stay in the shared world and ward off unshared states of mind become relevant. Earlier in this chapter, these two ways of knowing (shared and unshared reality) were linked to the idea that the human being has distinct modes of processing. The non-ordinary way can be variously labelled as 'spiritual' or 'psychotic'. Following the ICS model (Clarke, 2010, p. 107; Teasdale & Barnard, 1993), non-ordinary experience becomes accessible at high and at low arousal. This maps nicely on to clinical experience. People's voices and delusions tend to intensify with stress, and take over in hypnogogic and drifting states. Where participants return for the second group having completed their monitoring sheets, this usually becomes apparent. The point is illustrated using an adapted version of Linehan's 'States of Mind' diagram (Linehan, 1993, p. 109), in which the wise mind represents the ability to reflect on your experience while grounded in present reality. This leads naturally into the crucial role of mindfulness, as well as discussion of arousal management – whether

using breathing control, relaxation or exercise as a means of managing high arousal, or engaged activity to avoid low arousal. The latter can present a challenge in hospital!

11.5.4 Role of Mindfulness

Such strategies enable the individual to manage symptoms essentially by disengaging from them. Applied consistently, this would represent avoidance, with all its associated problems. A balancing strategy of facing the unshared experiences, however frightening or seductive, is needed. Mindfulness provides such a strategy, with a sound research base (e.g. Chadwick *et al.*, 2005, 2009). Even before mindfulness swept the board, a similar strategy had been explored by Haddock (1998) (but this was called 'focusing') in an elegant study that is now introduced to the group. Again, it is stressed that such focusing or mindfulness requires courage, whether for fear of being overwhelmed by the experience or because it means facing its unshared nature, along with the possibility that a cherished idea, even a cherished identity, is unshared. The mindfulness exercise used requires the individual to ground themselves firmly in the present and find a strong, centred place from which to embark on this challenge. Once introduced to the exercise, participants are encouraged to practise between groups.

The last session is an opportunity to review the group, to return to the goals identified in the first session and to introduce the possibility that openness to these experiences might have a role in the wider context of each individual's life. This aspect is introduced quite lightly, in what is a very brief programme, by initiating discussion of the pros and cons of using coping strategies to manage 'unshared reality', acknowledging that this is a matter of choice and that there are arguments on both sides, while emphasising that the group agenda is to try and coax people to join the shared world. This is made harder where the individuals have been offered a devalued and stigmatised position in this world by virtue of their diagnosis and unshared reality offers a more exalted position, even if it is accompanied by frightening experiences.

Another research-based idea, Mike Jackson's problem-solving hypothesis – which suggests that psychosis occurs in response to life reaching an impasse, and that if it is followed by orderly return to the shared world, it can result in new and transformative insights, illuminating a better way forward (Jackson, 2010) – is then introduced and discussed. The significance of early breakdown experiences often emerges at this point, through recognition that times of stress, specific trauma, or both, preceded the initial breakdown. This more positive, problem-solving and potentially transformative perspective is floated lightly. It resonates with some participants, but not others. We conclude with the participants marking where they have reached on their goal-setting visual analogue line and completing questionnaires.

11.6 Psychosis as a Spiritual Crisis

This positive, potentially transformative perspective draws on the spiritual emergency literature (e.g. Grof & Grof, 1991), which emphasises the transformative potential of such experience (Brett, 2010; Hartley, 2010). According to this school of thought, such crises, occurring at times when growth and development are somehow blocked, open the individual to forces either beyond or deep within themselves, or both. The foundations of the everyday sense of self can be rocked by such experiences, which are frequently deeply disturbing and frightening. The classical presentation (e.g. Grof & Grof, 1991) distinguishes such states from psychosis. Indeed, some people navigate such psychic breaks successfully in a way that enriches their lives despite accompanying disturbance, while others become lost in a psychotic state that does not confer apparent benefit and can become a recurrent affliction. However, I would argue that there is no intrinsic difference in the state itself. Such states can be understood in ICS terms as a temporary desynchrony of the two central meaning-making systems (Barnard, 2003 explores this in detail).

If we are to rethink psychosis in these terms, and Jackson, Brett and Heriot-Maitland all invite us to do so on the basis of their sound and thorough research, far-reaching and radical implications follow. 'Symptoms' are no longer an aberration to be eliminated with medication. Yes, they need managing for the sake of the individual and in order to maintain the safety and tolerance of those around them, but not necessarily to the point of obliteration, not least because the individual needs to retain some ability to navigate what is now recognised as an important process, with potential spiritual and growth implications. Services need to be prepared to support this process, even where it means greater tolerance of socially and culturally unacceptable behaviour, and this behaviour might require temporary containment, more on the Soteria model than in the current psychiatric hospital (Bola & Mosher, 2003). The role of medication is relevant here. To take a balanced approach: neuroleptic medication can release an individual from being locked in a private hell; it can make possible the management of ordinary life and inhibition of risky impulses. However, the services as they are currently set up are essentially addicted to this medication as the only solution, even where it confers little benefit. A more humane approach takes account of the individual's perspective on the process, rather than swamping it through over-sedation, reinforced by an apparatus of legal coercion. Supporting the mindful facing and accepting of inner experience, at the same time as recognising the broader perspective, offers the individual dignity and control, and ultimately choice, which is sadly often denied by current services.

At the same time as evidence builds about the limitations and harmful side effects of the medication solution (e.g. deleterious effects on motivation, see Arias-Carrion & Peoppel, 2007), the growing body of research evidence cited in this

chapter recognises the spiritual/growth and transformation potential of psychosis, thus presenting a challenge to the mental-health system as currently constituted. Alternative approaches such as Soteria (www.soterianetwork.org.uk) and the Spiritual Crisis Network (www.spiritualcrisisnetwork.org.uk) provide a vital balance and an alternative perspective. Within the health service, we need to develop and make widely available a psychological therapy that offers the opportunity for the individual to take control of their own journey in this unpredictable territory. In this way, recognition that spirituality and psychosis are closely allied can lead to a transformation in the therapeutic approach to psychosis.

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