Schizotypy and the experience of transliminal phenomena.

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I am conscious that the words 'transliminal' and 'schizotypy' are not ones that trip lightly off the tongue, and also that while one indigestible word in a title is bad enough, two is going a bit far. I need these words because they refer to experience. The transliminal is a facet of human experiencing for which I have not found another suitable descriptor. The questionnaires that determine an individual's position on the Schizotypy continuum tend to ask about beliefs (Claridge, 1997), but the sort of beliefs that will be grounded in the extent of someone's acquaintance with, and attitude towards, anomalous experiences. These terms are necessary as I am going to take experience seriously as a way of knowing.

So, why appeal to subjective, unverifiable experience? Why not rely on scientifically established, objective facts? Or turn to learned authorities? What has the (possibly somewhat batty) individual to say that should be taken seriously in the face of all this learning? At the heart of my argument is the contention that we have been missing half the data by not attending to it, and an important half at that.

Two ways of knowing

I came to the study of psychology in mid-life, with a host of questions I wanted answering. I wanted to understand why human beings were so fragile, so prone to breakdown. I wanted to understand religion and spirituality, which had always been central for me despite this being a deeply unfashionable position for an intellectual in the 1960s of my youth. The mass of experimental findings of cognitive science into the modular nature of memory, different neural codings, bottlenecks in information processing and the like were clearly relevant, but I could not see the wood for the trees until I chanced upon the Interacting Cognitive Subsystems (ICS) model of cognitive architecture (Teasdale & Barnard, 1993) and all was revealed.

According to ICS (which has been largely ignored by everyone else, but that is another story), there are two overarching, meaning-making systems organizing the complexity, developed according to evolutionary need. One, called 'The Implicational Subsystem' in ICS, receives information from all the sensory subsystems and connects with the body's arousal system, and so has the ability to respond rapidly to threat and opportunity. The other, 'The Propositional', is the seat of the unique, human, evolutionarily-advanced verbal systems, with their attendant faculty of precise thought and prediction. The crucial point is that neither is in overall control and during ordinary functioning, they pass dominance back and forth between them. As Teasdale says: 'there is no boss'.

The relevance of this to human experience is that it means we have two, distinct, ways of knowing. When the two systems are in close communication, we have full access to that

precise - but essentially filtered and so incomplete - way of knowing, that tends to be accepted as the norm. In this state, we are grounded in our individual self-consciousness; we pretty much know who we are and where we are going. This tends to mask the importance of the experiential knowing ingredient in the process. That is governed by the other default system and reaches beyond the limiting filter - beyond individuality towards the whole. We are most familiar with this way of knowing through appreciation of art, music, the glorious sunset etc. When the balance of control shifts towards this 'implicational' subsystem, we can access the human faculty of stepping beyond our individuality; encountering the whole in a mystical experience; encountering terrifying forces beyond or within (which are now the same, as we have stepped beyond a place of distinctions) psychosis. (For a fuller exposition of this, see Clarke 2008, 2010a). It is this faculty of human experiencing for which I adopt Thalbourne's term 'transliminal' (Thalbourne, 1991) as used by Gordon Claridge in the schizotypy literature (Claridge, 1997, 2010), meaning (from the Latin) 'beyond the threshold'.

A dimensional view of openness to anomalous experiencing.

This might sound like quibbling about semantics, but I would argue that the perspective revealed by using this term has far-reaching implications, not least for those whose experiences have resulted in the diagnosis of psychosis. Instead of talking about illness and pathology, we are looking at a universally accessible facet of human experiencing, one that, given the right circumstances, is open to anyone. Of course, those distressed by terrifying and disorienting experiences and whose functioning is adversely impacted as a result, need help and support. But the way in which this is offered, the frame of reference presented, has important implications for the individual in terms of self-image and hope for the future. This is where schizotypy comes in.

In the group programme I developed for people in this category while working for eight years as the clinical psychologist attached to an inpatient unit, the concept of schizotypy was introduced in the first session. The group was called the 'What is Real' group (Clarke, 2013, 2010b), and started by taking a broad overview of anomalous experiencing, with reference to selected research. Not surprisingly, people for whom this was a part of their life were interested in it. We referred to Romme & Escher's 1989 hearing voices work, and the study of Haddock et al. (1998) comparing focusing (for focusing read mindfulness) and distraction coping strategies, as well as Claridge's schizotypy research. In the hospital, I used the terms 'shared' and 'unshared' reality instead of transliminal – not perfect, but reasonably easy to negotiate agreement around. This is an essentially collaborative approach.

In order to help people sort out which reality, shared or unshared, they were experiencing, we looked at the characteristics of unshared reality: dissolution of boundaries between people and coincidences; a powerful sense of meaning – or meaninglessness; the self either supremely important or lost in the whole; emotions swinging between extremes or entirely absent. This is a place of paradox and paradox is a constant in spiritual/religious traditions. Underlying this paradox is the significant distinction that while shared reality is governed by a logic of 'either/or', unshared reality/the transliminal works on a logic of 'both/and' (Bomford, 1999).

Having established what we were talking about and having discussed the pros and cons of the different states (e.g. unshared reality can result in involuntary detention under the mental health act: shared reality is boring), it was time to introduce schizotypy, or the dimension of openness to anomalous experiencing across all people. This has been extensively studied by Gordon Claridge and his collaborators in Oxford (Claridge, 1997) who established the differences between high and low schizotypes. The conclusion is not that high schizotypes will inevitably find themselves with a diagnosed 'illness', though they will have a greater vulnerability to this type of breakdown compared with the low schizotype. It does find association between high schizotypy and valued characteristics such as creativity, sensitivity and spirituality. This is a welcome corrective to the depressing messages that group members had been receiving up until now about their situation.

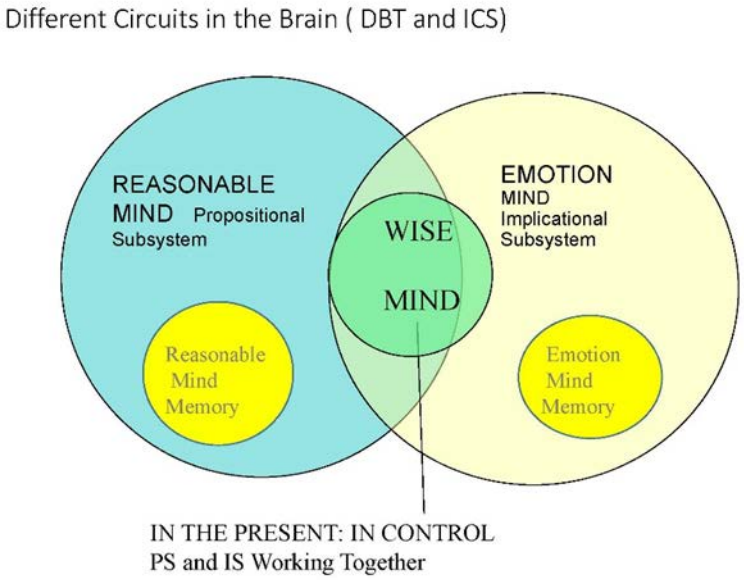
Managing the threshold.

Giving this corrective message is not just a matter of being nice to people; it has real clinical implications. The aim of the group was to encourage the participants to work towards managing their unshared reality, and therefore the risk that had brought them into hospital. This meant forming a collaborative alliance to use coping skills such as mindfulness. There is a growing evidence base for the application of mindfulness to psychosis (Chadwick, Newman-Taylor & Abba, 2005, Dannahy et al., 2011). Mindfulness of unshared experiences can require considerable courage and determination where, for instance, someone is experiencing terrifying voices, or where their unshared reality gives them a powerful identity, when shared reality offers only a seriously devalued one (Harder, 2006). Motivation is a key factor when asking people to engage in something this challenging. A basic tenet of motivational interviewing is the need to build self-esteem at every opportunity, as only when someone has achieved a reasonable level of self-efficacy will they be prepared to consider taking on the challenge. The stigmatized identity offered to those diagnosed with psychosis is a barrier here. Conveying the normalizing message of the schizotypy continuum is a first step to softening this barrier.

Next, the group considers the different circumstances that lead to the crossing of the threshold: times of transition; trauma which loosens the boundary and makes crossing the threshold easier; illness and loss; physical privation – lack of food, sleep, isolation, and of course, mind-altering substances. All apply equally to ascetic spiritual practices and vulnerability to psychosis. Even mind-altering substances have a place in some religious practice, from ayahuasca ceremonies to communion wine. My earlier career in medieval history meant acquaintance with the spiritual literature and the knowledge that the saints and mystics often first encountered the transliminal at times of illness and transition, and that their experiences of it could be terrifying as well as ecstatic. Monasteries and groups of acolytes could be convenient for cushioning cases of temporary adverse impact on day to day functioning of transliminal journeying. Our society is less accommodating.

The group participants invariably came up with all these circumstances that had resulted in finding themselves on the other side of the threshold or that drove them deeper into unshared reality. Given a commitment to keeping themselves safe and on the right side of the

mental health establishment, this gave plenty of openings for work on for future management of the threshold, and management of their vulnerability to finding themselves across it. Understanding more deeply what was going on in terms of the brain, conveyed by the handy 'States of Mind' diagram from Dialectical Behaviour Therapy (Linehan, 1993, p .109) was helpful here.



This diagram, which shows the Reasonable Mind (the propositional) and Emotional Mind (the implicational) overlapping at Wise Mind (the two working together to produce operating in shared reality) introduced a more fine grained range of coping strategies. Mindfulness, firmly based on grounding and with plenty of prompts (Chadwick, Newman-Taylor & Abba, 2005, Dannahy et al., 2011), is an obvious means of gaining an objective, observer stance, in respect of disturbing experiences. The fact that the level of arousal governs whether the implicational and propositional are synchronised or not leads immediately to straightforward management tools. The desynchrony (see Barnard, 2003) that ushers in transliminal experience occurs at high (stress) and low (sleep, drifting) arousal. Simple arousal control measures such as relaxation breathing and stress reducing life style changes, as well as concentrated activity in the present, become key strategies for maintaining shared reality. Those who value their unshared reality (more common than generally credited) can see that if they do gain sufficient control to manage risk and be allowed to manage their own lives, they will still be able to access it in a more measured fashion.

In summary, the basic therapeutic approach suggested by this model is:

- Validate the experience as *their* experience
- Validate the emotion (as opposed to 'the story')
- Sit lightly with explanations – *all* explanations, including medical and CBT ones
- Model sitting with uncertainty, recognizing mystery
- Introduce 'shared' and 'unshared' reality as a way of talking about this
- Helping the person to take control of their 'unshared reality' is key – how to close off openness to invasion – from within or without. Offering a non-stigmatized identity as a high schizotype is a good start here.

Potential for Transformation

In the final meeting of the group, we offered a glimpse into a wider dimension, one which is embraced by the Spiritual Crisis Network (SCN). This involves the positive and transformative potential of transliminal journeying (Brett, 2010). Traditions such as Psychosynthesis and Spiritual Emergence/Emergency recognize the transformational potential of the transliminal. Stanislav and Christina Grof are important pioneers here (Grof 1988, Grof & Grof, 1991). Carl Jung's work covers meeting and integrating the Shadow as a route to individuation. The hero's journey provides a framework where the descent into the underworld and attendant trials is followed by the return, bringing a gift to the shared world. (Campbell, 1993, Hartley, 2010).

These traditions tend to distinguish between 'psychosis' and transformational crises. More and more this is seen as a false dichotomy and this is the line taken by the Spiritual Crisis Network (UK). Mike Jackson (2010) whose research is cited below, argues that a trip into the transliminal is a natural response to impasse. It can result in new direction, new creativity, or the individual can find themselves trapped by a vicious circle of isolation to manage their sensitivity, driving them deeper into unshared reality. The assault on the self, represented by the stigma of diagnosis, will only intensify this process (Read, Mosher & Bentall, 2004).

Research

This research by Jackson (1997, 2010), along with Peters, (Peters et al., 1999, Peters, 2010) opened up the field. Jackson studied the phenomenology both in a large sample and in a more in-depth qualitative study, and Peters initiated a body of research looking at the significance of context for the impact of unusual beliefs and experiences. More recently, in the work of Brett et al., (2009), Brett (2010) and Heriot-Maitland, Knight & Peters (2011), comparable experiences for people in different contexts (clinical or non-clinical) have been shown to result in significantly different life adaptation. Caroline Brett's AANEX questionnaire (Brett et al., 2007) makes it possible to measure anomalous experiences phenomenologically and so get away from symptom language. Both Brett and Heriot-Maitland's research demonstrate that having a benign social or spiritual context for anomalous experiences has significant influence on whether they result in diagnosable mental health difficulties, and whether the anomalies/symptoms are short lived or persist.

Conclusion

Taken together with robust epidemiological findings (Warner,1985, 2007), this data points to the conclusion that non-pathologizing ways of conceptualising such experiences, of which use of the concepts of schizotypy and the transliminal and the 'What is Real' programme are examples, are the best way to achieve good health outcomes. It is for this reason that in addition to my work in the NHS, I am secretary of the Spiritual Crisis Network (www.spiritualcrisisnetwork.uk). The SCN promotes awareness of this alternative conceptualisation and of the positive potential of adequately supported transliminal journeying.

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