**Conflicted Stories. A case of expanded reality.**

Isabel Clarke and Tilda[[1]](#footnote-1)

As human beings we have experience and we have story. We tend to shape the experience with story into a form that makes sense, is comfortable for ourselves, and presents us in the best light to others. In the case of psychosis, and other exceptional and anomalous experiences, the experience threatens to overwhelm story. In these circumstances, the obvious recourse is to go to the ‘experts’, perhaps the doctor, who has a ready story based on the medical model. You are ill. We can treat you. Cognitive Behaviour Therapy for psychosis (and other psychotherapies) have a different story, based more on what has happened to you and emotional overload, but in judicious deference to superior power, this story tends to slot neatly into the medical model. There are of course, other relevant stories. Spiritual emergence/emergency (Grof & Grof 1991), Shamanism, Power, Threat Meaning Framework (PTMF: (Johnstone & Boyle 2018)). Tilda, the experiencer whose story is featured in this chapter, was bounced between stories, and her history is instructive for all of us who assist travellers accessing the further reaches of the mind.

Introductions are in order. I am a therapist – I trained as a clinical psychologist in mid-life, my career change driven by a passion to find a more helpful story for mental breakdown. I have worked in the UK National Health Service (NHS) for 30 years, with a focus on people with complex problems. However, Tilda is not ‘a case’: she is not my patient. She is a colleague in the core, managing, group, of the Spiritual Crisis Network UK. I am a founder member of this organization that offers a more hopeful story than the medical one to anyone who recognizes the spiritual dimension to their struggles with alternate realities, and provides sensible but optimistic support. Tilda has agreed to collaborate with me in presenting her account of a resilient individual, a single Mum who has pursued a successful career (in mental health), despite a number of excursions into alternate realities that have also taken her into the heart of the psychiatric system; the inpatient unit; more than once.

**Tilda’s early journeys in expanded reality.**

Tilda’s first experiences of alternative realities; anomalous experiencing – however you would like to describe it, came through engaging with the 1990s party scene, fuelled as it was by a variety of substances; ecstasy, MDMA etc. Tilda emphasized that this was a leisure pursuit. Her career as a young mental health nurse took precedence, and she saw herself as a well-grounded individual, with no dependency or unhealthy relationship with the substances she enjoyed as part of the social scene she engaged with. It was a magic mushroom omelette ingested when on holiday in an idyllic beach location in Thailand that really ‘opened a gateway’ to a ‘God-like experience’, enveloped in and enhancing perception of the beauty of the natural surroundings. That experience, and another where she experienced effective spiritual healing in India, opened doors to a new interest in things spiritual and in spiritual healing such as Reiki.

Tilda emphasized her natural scepticism, and indeed the groundedness that enabled her to engage in unusual experiences and then come back to the normal world. Where she began to explore spiritual healing and Reiki, learning to become a healer herself, she started to experience a clash of stories. For seven years she had been working in mental health nursing, and achieved the transition from wards to community work, which she loved. Professionally she was steeped in the medical story, but was now encountering an alternative both at the level of theory (story) and experience – she had received and was delivering spiritual healing. So far so balanced, but it is at this point, in 1999, when things got out of hand and the venture into new conceptual realms landed her in the psychiatric hospital – as a patient, not a member of staff.

**A New Scientific Story**

Studying psychology in mid-life, I had been keen to make psychological sense of two areas I had identified as being incompletely understood; spirituality and mental health, and my explorations led me to a common source for both, which I have written about extensively elsewhere (Clarke 2008, 2010, 2021). What follows is informed by the Interacting Cognitive Subsystems model of cognitive architecture (Teasdale & Barnard 1993), which is solidly grounded in the findings of cognitive science about pathways in the brain; what is connected and not connected to what, and where there are bottlenecks; in short, the limitations and idiosyncrasies of human processing that are screened out of awareness as we cannot know in any other way.

In summary, our two ways of knowing – experience and story, or being and thinking about, are rooted in our having two separate circuits in the brain. The sophisticated, verbal one developed as we needed more specific communication to manage living in larger groups, and finer tuned tool use with the development of the hand and fingers (Barnard 2010). This new capability was bolted onto the original processing capacity, which was focused on survival, as our evolution progressed from animal to human. Working together, these two networks in the brain give us a great degree of control over a considerable, but ultimately limited range, and filter our experience. The two circuits will loosen and separate in specific circumstances – high or low arousal; taking substances etc. This opens the individual to that expanded consciousness that is sought in drug and in spiritual experiences. However, it takes the person away from their groundedness in their individual self-consciousness and boundedness within their skin. This is fine for a short time, but if allowed to take over too far, or where the route back is lost and the person is stranded in this state, it can quickly become unmanageable and even dangerous. This view recognizes the positives associated with such states – the way they can open an individual up to new creative possibilities, as Tilda was opened to the spiritual and to healing. However, it also recognizes the dangers and the need to learn to manage the threshold between the two states, by remaining grounded in current physical reality and the shared world. This is what SCN teaches.

**Tilda’s Breakthrough, Breakdown, experience.**

By 1999, Tilda’s earlier party, drug induced, experiences were giving way to a deeper appreciation of spiritual states and the powers, particularly of healing, that went with these. Time in India where she experienced effective Reiki healing on an ankle injury, and went on to learn Reiki herself, chimed in with a friendship group taken up with new age spiritual exploration through reading and workshops. This new story about healing was pursued in parallel with the medical model dominated environment of her profession as a psychiatric nurse. However, moving from working in a hospital into the community gave this work a freer and more therapeutic character.

Tilda managed to keep these two worlds in balance until one memorable weekend when, in her terminology, she experienced a popping open to a spiritual awakening – I see ‘popping’ as crossing the threshold between the two processing capacities, the two ways of knowing; crossing from sharing control, so keeping things manageable but limited, into the place of expanded consciousness, where that safety is left behind. I am handing over to Tilda to relate what followed;

“The healer that I was following was doing a weekend workshop, and I was looking forward to it. I had been feeling in the flow, and experiencing synchronicities. The breakthrough came while doing distant healing with someone I met in the pub – the healing I had been taught to do. I met by chance whilst with friends, having a couple of drinks, (no drugs). While doing the agreed distant healing later, alone, I had the experience. I initially entered into a very peaceful state, contented. I then experienced a time warp in from a traumatic incident when I was 10; I had been resuscitated following having been run over by a car. From that time onwards all my life flashed before me, even the minutia: a near death experience displaced. Arriving back in the present, I felt enveloped by all-encompassing love, beginning with myself onwards to all humankind which spread out to all sentient beings, raising above earthly matters to the universe beyond, making me at one with the universe. I received insight that my healing was true. Before that, I had been sceptical and in two minds about it, though people had been giving me feedback that they had results. The peak experience came to an end when my rational mind kicked in and I became consumed by the idea that this was an initiation into becoming the/a messiah. From there it dissolved as my rational mind became scared of the implications of that. 22 years later my only regret around this experience, was that I did not sit with the peak for a little longer.

After that profound experience, I remained awake through the night, absorbing the enormity of what had occurred, whilst I was relatively calm until the morning. Getting up for the day, I found myself now filled with excitement and arousal at the possibilities. I was experiencing my thoughts as never before, seeming linear, all lying there together as if I could think all things all at the same time, whilst feeling really calm about that. Amongst that was a feeling of 3: there would be 3 events. I also had what appeared to be a download of information. I had been staying at the house of spiritually attuned people, who were accepting of it being a spiritual experience. In an experiment, an encyclopaedia was brought out, and I could answer any question posed to me from the broad range of material.

I should have stayed at their house. My mistake was to phone my Mum and say I was going to heal the world. She organised for me to be taken to hers to be seen by an out of hours GP. In my innocence, I told him my framework and told him I really needed something to help me sleep, and was hoping to get into my comfortable bed as I instinctively knew I needed calm time. Instead of which, he told my family I needed to go to Accident and Emergency (A&E) as I was psychotic and could turn violent at any moment. Manipulated into appeasing the family against my better judgement, I went along with it. A&E made things worse as there was a four hour wait in what was a far too stimulating environment, given the experience I had been through.

By the time I was seen and was undergoing Mental State Examination, my brain was completely scattered. My need to go home to sleep was overridden. I was persuaded to take Haloperidol, and was put in a side room. It was half an hour after consuming this that my peace came crashing down and I experienced unbearably loud screaming in my ears and could not get up to seek assistance, instead seeing black ghost/shadow figures until unconsciousness took over. I woke up in the Acute Psychiatric Ward. W In the morning, I was dumfounded, so shocked at now residing in a room rather than being on duty as staff. However, by the evening I had, as the medication wore off, been able to gain clarity and the insight that they considered mine a mental health presentation. It seemed I could not then go home, I was in disbelief how easily the powers of detainment and medication against your will was do-able. I had the misfortune to meet the ward manager from hell.

I was in hospital for 10 days until a Tribunal released me, after which I went to Ireland, where I had family, to settle and chill out. I felt highly traumatised. I had been injected against my will, being surrounded by men and given Acuphase in my backside; an awful drug mostly used in the case of potential for violence. It annihilated me physically but I learned then it gives no relief to the mind, just prevents you from moving effectively or to be able to string together sentences. I couldn’t cope. I was dribbling and suffering inside. I had a realization around what my patients had been through, all those years I had been working in Acute. They had told me, however I had only a limited ability prior to my own experience to fully understand.

At this point I had fallen out with Mum. Because I didn’t want to speak to her because of her failure to recognize the abuse, I was undergoing in hospital, preferring the view that the professionals know best, she phoned the services describing me as in breakdown. I had a near panic attack when they arrived unannounced at my door. This led to me being sectioned and brought straight back to the traumatic ward scenario, that I was trying to escape.

I shifted strategies and realised it was best to go with it. I accepted I needed their medication and subsequently proceeded to give appearance of compliance with the prescribed Olanzapine. Only in Northern Ireland can it be that when you phone a solicitor would they give you the advice to get over the border. A work colleague I phoned advised I did not sound drowsy enough, so it was unlikely I would be getting the early discharge I was hoping for, one where I could get back to enjoying nature, and indeed enjoying this new found expansion, within which I never did lose touch with reality, provided I was in an environment of my own choosing. So, with careful planning, I managed to escape.

I got to Dublin, where I stayed with my uncle and his family. I had sought him out, knowing him to be my wise uncle. I was right, and in doing so I made much more progress. For a man with no actual experience in psychiatric matters. he was the first who was able to assist me in seeing what others’ concerns were in a comprehensible way, by being respectful of my experience, whilst pointing why other people were worried. Unlike myself at that point, he could see what others could see.

I moved on from him to the family farm, now with another uncle who had lived there all his life. The simplicity of his life was the grounding that I had instinctively known I needed. I was still in an altered state, whilst, as from the beginning, I felt quite in control of it, and could experience it in this sanctuary. My uncle, who had known me all my life, was easy going and offered me the space to do so.

Unfortunately, my peace was again shattered following my father having used the ability to have me sectioned yet again, on the grounds of my escape. I was hoodwinked into entering outpatients quite sure I was not detainable: however, papers had already been signed. I was surrounded by numerous nurses, walked down to a bed; told to lie down with no information as to what was occurring and was injected. I subsequently found out I was on section, and there was no right to appeal; no right what so ever to object to medication and no advocacy, and the nurses were dreadful. Southern Ireland psychiatric services were in the dark ages.

I came home as a shadow of my former self, experiencing panic attacks for the first time in my life. I was defeated by the meds and accepted the medical model. I was so traumatised from my experiences, that my actual life had turned into a living nightmare, whilst my internal world had experienced so much discovery that was being so interrupted, and ultimately repressed. It left me feeling I had let myself down when the drugs crushed me: for instance, how stupid I had been to believe that my experience was valid. I carried on with the meds for 6 months, and they had disturbing side effects. I was detached from myself; I just loved going to sleep at night, thankful I now had easy access to Valium in addition to the anti-psychotics. I did continue to be out with friends at all opportunities, as I found it not so easy to sit with myself. However, I was not responding in social situations, rather just becoming a quiet bystander, the opposite of the way anyone had ever known me to be. I was informed afterwards by people who had known me before, how upset they were at this apparent loss of the friend they had known. Having heard I’d had a “breakdown” people assumed that my side effects from the drugs was it.

**A Clash of Stories**

Tilda’s account nicely illustrates three different positions that can be taken in relation to such experiences, and the difference in outcome for each. To start with there was the spiritual and transformative experience, going with the flow, at one with the universe, synchronicities abounding, access to new powers of knowledge and healing that worked well for quite a while. A social environment that was supportive of the spiritual world view combined with staying grounded in employment helped to sustain the peak experiences safely. However, there came a time when it went over the top, and telling other people such as mother about special mission and abilities raised alarm bells.

According to the medical story what was happening was simple. Tilda was ill, probably with bipolar disorder, and this needed to be crushed as quickly as possible using powerful drugs and legal coercion. Her viewpoint was not to be heeded as she was ‘out of her mind’. According to my, spiritual, understanding, she had for some time been managing the threshold between the two ways of experiencing: the ordinary, everyday one and what I call ‘the transliminal’, following Claridge (1997) (which is the Latin for across the threshold). Because crossing this line means leaving behind individual self-consciousness and moving into relationship with the whole, it leaves behind the sharp distinctions we are accustomed to in our everyday life. Things feel connected – hence the synchronicities. The sense of self becomes fluid – hence the new messiah feeling. Clearly all this has its dangers, but it did summon real powers of healing for Tilda and was life enhancing without the artificial assistance of drugs. The existence of a supportive social milieu, accepting of this potential of human experience as something positive and to be pursued was important for its remaining in balance.

The effect of the medical establishment taking charge was to shut down, side-line and devalue all the positives that went with the spiritual perspective. All agency was taken away from Tilda. She was confined in a frightening environment and forcibly given powerful drugs with side effects more disabling than the original imbalance. Moreover, in removing the positive story she was given a new perception of herself as defective and unstable, defeated by the system, whereas her first instinct had been to rebel. Again, the importance of the social milieu can be noted. Tilda’s mother, sister and father were all indoctrinated into the medical perspective, which teaches fear of anomalous experiencing, leading to coercion and not listening to Tilda’s point of view.

The third perspective is the balanced one represented by the wise Irish uncles. They accepted that Tilda was not fully functional and so needed temporary support and protection until she regained her balance and was able to operate efficiently in the ordinary world. Her Dublin uncle helped her to see things from the other side of the threshold in terms of her impact on others. The calm atmosphere provided by her rural uncle was enabling her to get back together, when her father’s intervention, instructed by mother and sister, disrupted the slow healing and plunged her back into the medical story.

**Schizotypy**

The entitlement of the medical world to take charge and coerce in these circumstances rests on the assumption that this is the scientific approach. Our society’s unquestioning deference to science is soundly based on the material benefits it has brought in terms of control over the environment and progress in physical medicine. However, it has been pointed out that Psychiatry’s claim to this status is flimsy. The concept of distinct mental ‘illnesses’ has been effectively challenged (e.g. Bentall 2003, 2009, Boyle 2002), and the operation of psychiatric medication has been shown to be miss-sold as ‘cure’ for these fictitious conditions (Moncrieff 2008). It is undeniable that these medicines do have an effect, and have a place where someone is in overwhelming distress or a danger to themselves and others, but they operate more simply by modulating state of arousal etc. Whittaker (2010) and others have uncovered how the research on which the inflated claims are based is seriously unreliable, as overwhelmingly funded by pharmaceutical companies benefitting from the exaggeration.

There is a sounder strand of science that has been investigating this area thoroughly for decades in an unbiased atmosphere, and this is Schizotypy research conducted by Claridge and his collaborators (1997). Unfortunately, this has been a predominantly academic exercise with little overlap, until recently, with clinical application. Schizotypy accepts anomalous experiencing as on a continuum with ordinary experience, and as a potential open to all human beings, but more accessible to some than to others. It examines the neural correlates of these experiences, and the life circumstances creating greater susceptibility, as well as looking even-handedly at the effects for the individual of high Schizotypy (or openness to anomalous experiences – i.e. crossing the threshold).

The results of this research strand offer a very different story to the medical one. High Schizotypy does indeed correlate with vulnerability to psychotic breakdown, but equally with high creativity, sensitivity and spirituality – attributes that are highly prised in our society. I use this to rebalance the direly stigmatizing effect of the medical story on self-image in my approach to psychosis within psychiatric services – to be covered later.

High Schizotypy has been shown to be associated with both genetic predisposition and trauma, so I explored with Tilda where her susceptibility might have come from. On the one hand, she declared that, ‘if it happens to me, it could happen to anyone’ as she was a singularly well-grounded, pragmatic, individual. She also has a ready sense of humour, on hand to debunk anything over solemn and pretentious. However, there were also relevant factors in her background. Her extensive Irish family roots contributed both Celtic spirituality and Catholicism. She recounted a particular mountain she often climbed as a child where she felt a strong Celtic feminine memory; having a psychic dream from the Celtic world when her Granny died; a meaningful experience of spiritual healing in a church with an aunt. On the trauma aspect, there was the near-death experience of being run over age 10, and her most recent episode, which will be related next, came in the context of extreme stress and personal threat to herself and her son. All these experiences will have helped to prepare Tilda to cross that threshold.

**Bringing the Narrative up to Date**

Tilda did indeed have two more episodes following the one narrated; one she could attribute to smoking cannabis, and the second, with no apparent trigger, but once the experience had taken hold she did consume cannabis, leading to what she could more easily view as psychosis. This included a very humorous and enjoyable experience, witnessing the A&E doctors turning into fully grown farm animals, leading to the realization that “I’m clearly out of my head here”. Following a relatively brief admission to a private hospital and allowed to remain psychiatric drug free, she was recovered and back at work within 3 weeks. After that she was essentially stable for about 20 years. 10 years later she had her son, with no ill effects. She had delayed pregnancy fearing it might produce a relapse, until she felt confident that all that was behind her.

Though this episode was acute and she had found herself temporarily trapped in a nightmare hospital experience, she came through it determined to work for a truly therapeutic mental health system, The difference was that Tilda’s alternative story had developed considerably in the interval.

When going through the earlier episodes, Tilda had two separate stories that did not connect. One was about enlightenment and spiritual awakening, and the other was about mental illness. As a result she yo-yoed between the two, with the damaging medical one essentially winning in the end. Encountering first Emma Bragdon (e.g. Bragdon 2013) and then the Spiritual Crisis Network changed that, and provided a narrative that embraced both poles, along with techniques to manage imbalance. At the SCN conference in Mundesley, Norfolk in 2015, she said she met her peer group – people who recognized mental breakdown as, potentially, a stage in the process of spiritual growth and development. This process can be managed by grounding in the physical present and staying in touch with the normal, social, world, even though the mind might be in a completely different place. This is not about obliterating the experience as the medical approach dictates, but managing it, while aware of the potential risks and dangers that might ultimately make recourse to the mental health services unavoidable. Having a supportive social milieu is crucial for successful navigation of crisis. This is well illustrated by Tilda’s history so far. She was making good progress at finding the balance when she was supported by her Irish uncles, before her immediate family, with their fear and adherence to a purely medical solution, weighed in. SCN provides precisely this alternative context through its responses to emails and its peer groups.

Tilda threw herself into SCN, undertaking the training and joining the team of volunteers who compose responses to crisis emails. This entitled her to join the Core Group and participate in the running of the organisation. Consequently, when the intolerable stress of a situation with child protection catapulted her into another episode, she entered the system with a more elaborated and helpful story to counter the medical one, and bounced back relatively quickly and successfully as a result.

**Tilda resumes; the next instalment.**

As mentioned above, the background to my latest episode was a result of the intolerable strain of being placed incorrectly under child protection and monitored by social services through misinterpretations and incompetence, just as the Covid pandemic lockdown commenced. Despite being subjected to intolerable stress, I continued to work as an NHS frontline responder. A few months in, with the previous records of “mental illness” also being cited as a problem, I had no option but to be signed off work. I soldiered on, joining a weekly women’s development group which used archetypes, accessing a bespoke counselling by an ex-colleague who had created her own consultancy, with a spell in Ireland and using SCN grounding techniques, alongside their support group. At this point I hadn’t actually figured that I might be heading into another peak experience. I was more consumed with the miscarriage of justice, and ruminating unwanted thoughts. Finding it impossible to relax, I lost appetite, and resorted to chain smoking. All the while I was in lockdown and having to prioritise my son’s wellbeing. In the initial phase, whilst I had been able to offload on the phone to a trusted set of work colleagues, I put up a front around the neighbourhood, concealing the stress I was enduring, due to the apparent shame (it transpired that was incorrect as it was later revealed they had become my greatest supporters)

Six months into this stress condition, a letter from a solicitor that was a breakthrough, set the ball in motion in the other direction. It started with subtle experiences and coincidences that signified to me that we are aligned with the global emergency created by COVID. I identified with Demeter in the Persephone myth, and the Bat out of Hell album that I had sung my heart out to as a teenager in front of what had become my sacred mountain years later. I connected this with COVID and was aware of the presence of my deceased father and uncles, as well as the presence of my best friend from school who had died young

This new episode began as before with a relatively euphoric phase. I knew I had “popped” again. While this was something I had avoided for over the 20 years, once it took hold, it was addictive. I was aware of what was happening and of the need to stay grounded. I had some emergency meds, Lorazepam, that I had requested. I took that one night, and very unusually, had disturbing side effects that I had never experienced before with that drug.

The psychedelic experiences started to go faster. A fateful weekend, involving time in the pub and some alcohol, tipped things over the edge, leading to a trip in the back of a police van to a seclusion room, while experiencing that I was going to “burst into god”. I had lined up a safely held space with my trusted friend and was looking to make my way home to take more Lorazepam at the point when the police van arrived.

The mental health services became heavily involved. I consider that I was sectioned too early and really one should not be sectioned whilst intoxicated. Whilst the peak experience lasted a few more days, in the hospital environment, I would rather have had that within an environment of my choosing. However, I spent 14 days in an extremely unsympathetic hospital environment, where the nurses wandered around with clipboards, making no effort at communication. The ward round and tribunal (that failed to release me from my section despite the fact I had settled) were particularly invalidating experiences, taking more notice of my son’s social worker and other professionals than of me. I was treated as a person who had no rights, and they failed to recognize my realistic worries around care for my son while I was in hospital.

I was not given the opportunity to discuss my medication options with the doctors, rather given high doses of what it became apparent all the patients were prescribed. Whilst still holding on to the powerful experience I had just been through, I was not disclosing this to anyone within the ward, but palmed the meds as I didn’t want them to steal the magic realm. I found my grounding by supporting the peer group on the ward, who similarly were being ignored by the nursing staff, using my working knowledge to make the ward a bit more therapeutic, to the annoyance of the awful nurses and the amazement of the few more dynamic nurses. Not taking medication covertly was a dangerous strategy in this particular establishment as I was aware that they were very quick to administer the long-lasting depot injection, which brought much fear.

Once out of hospital, I was able to clear up misperceptions and so resolve matters with Social Services, resume normal life, return to work, and in fact, soon, secure a more senior position.

I have emerged from this experience if anything stronger and more determined to fight for a revolution in mental health services. Collaborating over this chapter is one element of that fight.

**Transforming the Ward Environment**

Tilda’s experiences well illustrate what can be wrong with the mental health services. The Comprehend, Cope and Connect (CCC) approach that I have developed within acute mental health services is an attempt to remedy precisely this situation by taking a person centred, individual formulation, based approach and applying it to the entire ward culture. This is covered extensively elsewhere (Durrant et al 2007; Clarke & Wilson 2008; Araci & Clarke 2016), so what follows is a brief summary.

CCC meets the individual presenting to the acute mental health service as someone whose coping capacity has been overwhelmed by events and experiences. They are coping in ways that make sense at the time, but when persisted with, simply reinforce the problem. For instance, when things feel intolerable, withdrawal and self-neglect, or attempting to escape through suicide, make sense, but do not ultimately solve anything and in fact make things worse. In cases like Tilda’s, where there is a tendency to cross that threshold, referred to above, into altered states of reality, this other dimension can offer a welcome escape, but one with inherent dangers.

For a significant proportion of people accessing mental health services, past trauma or adversity plays a role in producing the intolerable internal state. This phenomenon can be understood by reference to the two processing systems described earlier, that have been labelled experience and story here. Essentially, when the emotional, experience based, processing becomes divorced from the ‘thinking about’, story, system, contextual information held by the story side is lost. Crucially, this includes time, so that earlier threat experiences are added to current issues. There is also evidence that such experiences facilitate crossing the threshold (i.e. high Schizotypy). In Tilda’s case, it is probable that the near-death experience she had as a child contributed to her vulnerability here.

Ideally, each person accessing the service will be engaged to collaborate on a formulation that draws on these factors, in the form of a diagram that brings it to life (Fig 1). The overwhelming feeling is identified in the centre, along with immediate circumstances leading to breakdown and any past

----------------------------------------------

Insert Figure 1 here

-------------------------------------------------

circumstances feeding into it. The person’s strengths, potential, values and if any, faith or sense of spiritual connection, are then explored and named. The individual is met as a whole person, not just a problem. Then their current ways of coping, with short term gains these bring, along with the disadvantages in the longer term, are tracked. These form the vicious cycles keeping the person trapped. Breaking these cycles can then inform the agenda for the admission, whether by programmes delivered in the hospital or other forms of support and intervention.

It is not always possible to coproduce an individual formulation with everyone; lack of resource, and the capacity of the person at a difficult time can all impact here. However, the team can think about them together using this structure – but always staying with everyday, respectful, language that would be appropriate if coproduced. This thinking can then inform goals and structure for the admission. Programmes that fit naturally with this approach are often quite simple: arousal management both up and down, to help keep the two processing systems together; emotional coping skills so that the emotion can be faced and expressed rather than drive behaviour; self-compassion skills, and psychotic symptom management approached in a way that normalises anomalous experiencing and counters stigma (Clarke 2010, 2013). Crucially, all staff members are involved in this programme. Even if they do not coproduce formulations or run groups, they know enough to see their patients as suffering individuals trying to cope, and can help coach them in new skills using the available programmes.

There are a number of acute (and other) services employing this CCC approach in England, Scotland and Northern Ireland, and there are a few evaluation studies, though more are needed (Bullock et al 2020, Araci & Clarke 2016, Paterson et al. 2018, Durrant et al 2007).

**Conclusion.**

The account given by Tilda of her experiences will hopefully enable the reader to appreciate mental health breakdown more from the inside. From the outside, conventional, medical point of view, Tilda had a number of bipolar episodes requiring admission under the mental health act as she was non-compliant and lacked ‘insight’ – i.e., she did not agree with the psychiatrist. From the inside, exploration ‘across the threshold’, whether through spiritual healing or substances, was a valued part of her life, but did sometimes have a tendency to spiral out of control. At such times, her behaviour became erratic and she made disturbingly grandiose statements. Through much of these episodes, she retained an observing self – as witnessed by the fact that she was able to plan and effect escape with considerable efficiency. She was aware when things were getting beyond her and she needed help, but unfortunately, the help offered failed to take into account her preferences and was blunt and coercive. She was trapped between the two, conflicted, stories.

However, there is research that demonstrates that the scientific, medical, world needs to take account of the other story; research showing that how someone makes sense of their experiences has real consequences for health and recovery. Peters et al (1999), Peters (2010) looked 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, Knight & Peters (2011), comparable experiences for people in different contexts (clinical or non-clinical) have been shown to result in significantly different life adaptation. Spiritual and religious ways of making sense of anomalous experiences figure alongside mediumship and new age beliefs in the group being favourably compared with those seeing their episode in medical terms. Taken together with robust epidemiological findings (Warner 2007), this data points to the uncomfortable conclusion that much routine health service practice is producing iatrogenic harm.

I have long been only too conscious of this situation and have attempted to remedy it through my work within the mental health services, e.g.Clarke (2021), Araci & Clarke (2016), and beyond them, through SCN. Tilda joins me in this agenda in both these arenas, bringing with her the unique advantage of deep immersion in both.

**References**

Araci, D. & Clarke, I. (2017): Investigating the efficacy of a whole team, psychologically informed, acute mental health service approach. *Journal of Mental Health Journal*. 26, 307-311 <http://dx.doi.org/10.3109/09638237.2016.1139065>

Barnard, P. J. (2010). Current developments in inferring cognitive capabilities from the archaeological traces left by stone tools: caught between a rock and a hard inference. In A. Nowell & I. Davidson (Eds.), *Stone tools and the evolution of human cognition* (pp. 207-226). Boulder, CO: University Press of Colorado.

Bentall, R.P. (2003).*Madness explained. Psychosis and human nature*. London: Allen Lane.

Bentall, R. P. (2009). *Doctoring the mind: Why psychiatric treatments fail*. London: Allen Lane.

Bragdon, E. (2013). The Call of Spiritual Emergency: From Personal Crisis to Personal Transformation. Lightening Up Press: Woodstock

Boyle, M. (2002). *Schizophrenia: A scientific delusion?* London: Routledge.

Bullock J, Whiteley C, Moakes K, Clarke I. & Riches S. (2020). Single-session Comprehend, Cope, and Connect intervention in acute and crisis psychology: A feasibility and acceptability study. The *Journal of Clinical Psychology and Psychotherapy.* [*https://doi.org/10.1002/cpp.2505*](https://doi.org/10.1002/cpp.2505)

Claridge, G.S. (Ed.) (1997)*Schizotypy. Relations to Illness and Health* .Oxford: Oxford University Press.

Clarke, I. (2021). *Meeting mental breakdown mindfully – how to help the Comprehend, Cope and Connect way.* London & NY: **Routledge**

**Clarke, I. & Nicholls, H. (2018*) Third Wave CBT Integration for Individuals and Teams:*** *Comprehend, Cope and Connect****.***  London & NY: **Routledge**

Clarke, I. (2013) Spirituality: a new way into understanding psychosis. In E.M.J. Morris, L.C.Johns & J.E.Oliver Eds. *Acceptance and Commitment Therapy and Mindfulness for Psychosis*. Chichester: Wiley-Blackwell.P.160-171.

Clarke, I. (Ed.) (2010) *Psychosis and Spirituality: consolidating the new paradigm.* Chichester: Wiley

Clarke, I. ( 2008) *Madness, Mystery and the Survival of God*. Winchester:'O'Books.

Clarke, I. & Wilson, H.Eds. (2008) *Cognitive Behaviour Therapy for Acute Inpatient Mental Health Units; working with clients, staff and the milieu.* London: Routledge.

Durrant, C., Clarke, I., Tolland, A. & Wilson, H. (2007) Designing a CBT Service for an Acute In-patient Setting: A pilotevaluation study. *Clinical Psychology and Psychotherapy*. 14, 117-125.

Grof C, & Grof S. (1991*) The stormy search for the self*. London: Mandala;Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J.(2018). *The Power Threat Meaning Framework: Towards the identification of patterns in* *emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.[www.bps](http://www.bps).

Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. Basingstoke: Palgrave Macmillan.

Paterson, C., Karatzias, T., Harper, S., Dougall, N., Dickson, A., & Hutton, P. (2018). A feasibility study of a cross-diagnostic, CBT-based psychological intervention for acute mental health inpatients: Results, challenges, and methodological implications. British Journal of Clinical Psychology, 58, 211-230. DOI: 10.1111/bjc.12209

Teasdale, J.D. and Barnard, P.J. (1993) *Affect, Cognition and Change: Remodelling depressive thought*. Hove UK: Lawrence Erlbaum Associates.

Whitaker, R. (2010). *Anatomy of an epidemic*. New York: Broadway Paperbacks.

**Relevant websites.**

Spiritual Crisis Network <https://spiritualcrisisnetwork.uk>

Isabel Clarke’s website.

<http://www.isabelclarke.org>

Chapter in:

Clarke, I. & Tilda (2022 forthcoming) Conflicted Stories. A case of expanded reality.

In Diaz-Garrido, J. A. (Ed.) Towards a paradigm shift: clinical cases in psychosis .

Figure 1. Formulation Template



1. Pseudonym [↑](#footnote-ref-1)