The cost of being different:

Schizotypy, hyper-permeable Ego structure, and social reactions on spiritual experience

E. W. Harnack

Abstract

Schizotypy is a psychopathological concept that is inherently connected with spiritual issues, since it includes symptoms that could well be classified as elements of spiritual experiences. While some theorists suggest, therefore, that schizotypy may be partly interpreted as an expression of such spiritual experiences, the present concise case study indicates that non-spiritual symptoms of schizotypy may result from misunderstood and poorly integrated spiritual or other extraordinary experiences in a person's early biography. Against this background, Western society's way of dealing with individuals reporting unusual experiences must be questioned as a potential origin of psychological disorder.

Keywords: Schizotypy, spiritual experience, paranormal experience, exceptional experiences

Schizotypy and spiritual experience

The concept of schizotypy was developed in the late 1970s as a milder form or preform of schizophrenia (Spitzer & Endicott, 1979; see Fiedler, 1997) and therefore rubricated in the ICD-10[1] as part of the schizophrenic spectrum in section F2 (schizophrenic disorders) while the DSM-IV (Sass et al., 2003) perceives it as a personality disorder. Nevertheless, even the ICD-10 states: "Evolution and course are usually those of a personality disorder". Personality disorders can be regarded as permanent, in many situations occurring inflexible patterns of interactions between person and environment. Personality disorders are thus "personal attributions of interactional problems" (Fiedler 1997). They

[1] International Classification of Diseases by WHO, 10th version, 1990: www.who.int/classifications /icd/en/. Different versions of ICD-10 are circulating, e.g. different "German Modifications", besides the international online version. I refer to the official German translation of the international version of 1993 to be found in the bibliography.

can less stigmatizing be described as particularly dysfunctional personality styles. The classification of schizotypy in the schizophrenia spectrum, however, puts a different and associative emphasis on schizotypy, in which, according to the widespread opinion of schizophrenia, a quasi-biological disease entity is constituted. This touches the epistemological status of this construct, i.e. the naive assumption that a diagnosis adopted by the scientific community equals reality.

The epistemological status of psychopathological constructs, however, essentially depends on the underlying model. As is well known by experts, the ICD-10 abstains from an elaborate nosology in the sense of statements of causes and confines itself to the purely descriptive designation of operational indicators of a syndrome. The term syndrome is to be interpreted here strictly as the sum of the symptoms that occur together statistically, but not in the sense that the sum would be anything more than the summary of its parts. In fact, however, syndromes are often perceived as overadditive *diseases*, as if they were real entities, i.e., naturally occurring things (Lat. res). In such a (therefore so-called :) *reified* sense it is often assumed that a (for example, biological, or perhaps social) primary cause leads to a disease process, which then produces the visible symptoms (medical model analogous to Rudolf Virchow's conception of infectious diseases). This model is questionable for a psychological perspective (see Bastin, 1990), because it disregards the multifactoriality and transactionality (entangled conditionality) of psychopathological processes, and with regard to the meta level, the numerous social implications of disease constructions.

Besides this, the schizotypy concept has some features particularly interesting for a transpersonal psychology thus making it an excellent subject for debate. This is particularly evident with regard to the fact that schizotypy overlaps by definition with spiritual experiences. It does not separate the disposition for spiritual experience and its impact in exceptional perceptions on the one hand and the disposition and manifestation of pathological processes on the other, but puts both into one. Schizotypy in accordance with the ICD-10 is defined as "characterized by eccentric behaviour and anomalies of thinking and affect which resemble those seen in schizophrenia, though no definite and characteristic schizophrenic anomalies occur at any stage". Obviously, here an experience and behaviour is regarded as insane by resemblance to a disturbed behaviour of a serious form, namely schizophrenia, without presenting its specific characteristics. The arising impression that the schizotypy construct might be conceptually shaky is strengthened by the fact that the concept of eccentricity, i.e., a loosely identifiable "otherness", is in the heart of the concept. It is therefore not surprising that the schizotypy diagnosis is used less often in Britain, where eccentricity is not considered so much as a pathological deviation, than, for example, in Germany. Problematic for a spiritual understanding also seems that under the typical criteria of the schizotypy disorder "strange beliefs" are specifically mentioned which in the literature are clarified as a 'belief in clairvoyance, telepathy or a sixth sense" (Fiedler 1997, 182) – nowhere the mix-up of ideology and science becomes clearer than here.

It seems particularly questionable whether a "disease" can lead to such experiences, which are considered as characteristics of the schizotypal disorder. Because the characteristic symptoms of schizotypy remind us of experiences that were separated by transpersonal psychology as spiritual crisis from classical mental derangement (see Grof & Grof 1989). The relationship between schizotypy and spirituality thus sets a general precedent for the discussion about an independent phenomenon and construct field of spiritual crisis or spiritual experience. A particular problem in this context is the assumption of an autonomous pathological (biological) mechanism that leads to a clinical picture, part of which are experiences which in other contexts are connoted a neutral or positive as spiritual or (ideologically neutral) as Exceptional Experience (EE). This assumption, which is widespread within the medical model, pushes the spiritual experience one-way into the role of an effect (symptom formation), which derives from a primary pathogenic cause (neurophysiological, early childhood experiences, etc.). Within such an understanding there is simply no room for positive-resource-based perspectives on spiritual experiences as an independent and non-pathological phenomenon. On the contrary: It seems reasonable to suppose that categories like "schizotypy" or even "schizophrenia" in practice are frequently used to identify a person, who reported not more and not less than spiritual experiences. In other words: schizotypy would therefore be neither cause nor effect of spiritual experience, but in a common practice simply to be equated. Transpersonal psychology, however, has often pointed out that spiritual experiences, and even the emotionally unstable states of spiritual crises as intermediate stages of a maturation process, may not be confused with pathological processes and their adverse consequences (see, for example, Grof & Grof, 1989).

Jackson (1997) was able to demonstrate empirically that people who reach high scores in the schizotypy scale STA (Claridge & Broks, 1984) at the same time ($r = .50$) show more numinous experiences (measured by the scale "numinous experience" of the Spiritual Experience Questionnaire, Jackson 1997). This result is remarkable, as of 37 items of the STA at most six to seven items may already be interpreted in the sense of numinous experience and the high overlap between the two constructs is therefore no grounds for the assumption of circular reasoning because of a non-selective and survey material. Jackson interprets this outcome according to his view that schizotypy is a non-pathological trait per se, which predisposes in the benign case for spiritual experience, in the malignant case for schizophrenic decompensation. He places the concept of schizotypy in the preclinical stage, and therefore as a common ground of pathological and normal as well as exceptional psychological experience, but this blurs the clearly pathological term used in the psychological and psychiatric community. From my point of view, it would be better to use a more unconsumed term as a preclinical common preform of both schizotypy (and in turn of schizophrenia) as well as spiritual processes.

I suggest to call this common predisposition a "hyperpermeable Ego structure". Because not only phenomenological (descriptive) results easily set up a common intersection of spiritual experience and schizotypal disturbed persons, but there also seems to be a common psychodynamic basic condition of both. People who are especially gifted for

certain extraordinary experiences (in particular those for which altered states of consciousness are typical), apparently need a particular mental constitution for this gift, which can be represented in different theoretical concepts. We will show this by the theory of basic symptoms of schizophrenia and the psychoanalytic concept of ego weakness.

The theory of basic symptoms of schizophrenia is a way to clarify the coarse screen-like schizotypy features, also with the aim to detect a predisposition of schizophrenia even before the outbreak of the disease. At the same time these basic symptoms are regarded as the subtle cognitive and neuronal mechanisms of schizophrenia itself, i.e., as its own functional base. These include features such as interference and blockages in thinking, difficulty of distinguishing between imagination and perception, slight disturbances in language understanding, subtle changes in perception, a tendency to produce ideas of reference, derealization, and both thought acceleration and thought perseverance (cf. Klosterkötter et al. 2001).

A person who shows such anomalies would be, according to the traditional psychopathological model, simply threatened to prone schizophrenia and is therefore in a twilight area between morbidity (and being thus already in potential need of treatment) and a slightly deviation from norm. For a transpersonal perspective, on the other hand, we are dealing with a person, which only shows a certain basic set of cognitive functioning, which can yield both positive and negative consequences. This may turn out badly for the persons only if they – because of apparently added, e.g., social factors – suffer a schizophrenic decompensation, while in other circumstances they either continue to live normally or make a positive development including spiritual experiences for which they have a special talent out of their constitution.

In the psychoanalytic literature, on the other hand, schizotypal and emotionally unstable (borderline) symptoms can be classified under the broad category of borderline personality organization (Kernberg, 1996). This is characterized by a defect of ego development, respectively ego structure. Behind this lies the psychoanalytic view of the Ego as a regulatory structure towards the outside (switching between person and environment) and inside (switching between instinctual wishes and superego control). To accomplish this task the ego is equipped with cognitive functions such as perception, thinking, judging, remembering, or reality control, or dynamic features such as the defence of conflicts. Ego weakness manifests itself in accordance with non-specific failures of some of these functions or in specific defects, such as defence mechanisms (Kernberg, 1983). According to the internal and external regulatory function of the Ego, inner and outer Ego boundaries can also be weak and porous. A collapse of Ego boundaries corresponds to a psychotic state.

According to psychoanalytic thinking, especially the primary process content penetrates the internal boundaries between the unconscious and the Ego in psychosis or psychosis-related conditions, and subject-object mergers, confusion between inside and outside, therefore, which penetrate through the permeable outer limits. These same

states, however, in which insight into other worlds, spirits, the aura of people, the perception of angelic voices, out of body experiences and the like are experienced, have been regarded in all places and at all times - except for us - as states of extraordinary experience, journeys into another world, shamanistic trance, but not as morbidity. Therefore, it can be supposed that these very states will be experienced more spontaneously, especially when the ego boundaries are weak.

It appears that the psychoanalytic picture of an ideal state of solid Ego boundaries is quite culture-dependent and by no means mandatory. Because the idea of a self as a fortress with hard walls against the environment does not exist as strongly in other cultures. In many non-European cultures, in many Asian cultures for example, the Ego is usually perceived as very permeable and less sharply demarcated (Kakar 2006). It would therefore be possible that the psychoanalytic idea of a person functioning well in this world must have strong Ego boundaries, possesses validity just within a culture that demands exactly this from an individual. However, it is stressed even in the psychoanalytic literature that the strength of the Ego boundaries should not be confused with rigidity (Kernberg, 1983), suggesting the ideal of a personality being able to handle the permeability of their inner and outer limits with flexibility.

Accordingly, we can talk about a disorder of the Ego boundaries in the sense of a trans-personal psychology most likely where the Ego boundaries either open up completely uncontrollable to inner or outer worlds, or where they are so rigid, that these other worlds remain completely closed for such an individual. Unlike the usual way of looking at the "healthy personality" the transpersonal psychologist believes that the ability to only function well in the concreteness of the material world can at best be a limited objective. In this case, however, a further distinction between rigidity and “permeable strength” of the Ego boundaries is needed. Because with people who are prone to spiritual experiences, we can in practice find two types: firstly, persons who experience the other worlds in a sensual way, and, secondly, persons who experience the other worlds through mediation.

The first type of spiritual experience, which could be described as a trance type or “perception type” in traditional cultures is often the shaman in the broadest sense, such as a healer being possessed by a being or a fortune teller. This is the kind of experience, where we usually expect the permeability of Ego boundaries. The second type usually has such spiritual experiences in naturally altered states of consciousness (such as REM sleep) or meditative experiences, but also in just lightly or not altered states of consciousness (such as artistic inspiration, nature observation or introspection, and synchronicities) because he is quite firmly anchored in the ordinary state of consciousness, i.e.: his Ego boundaries remain stable easily. Most of his spiritual experiences are also far less sensual than by other mental qualities. A person with rigid Ego boundaries (we can call them "experience type 3") would, however, be characterized by the fact that they use an active defence strategy against the entry of transpersonal content that make them fear their (according to psychoanalytic theory indeed not very stable) Ego boundaries might break and they could fall into a psychotic state. Whether this defence function characterises

rigid Ego boundaries or whether it is just one possibility in addition to genetic or other biographical causes, remains open for now.

Such a theory of the necessary permeability of ego boundaries for spiritual experiences of type 1 or flexible ego boundaries for the experience of type 2 has the advantage that pathological deviations (uncontrollable permeability as a possible slippage in the first type and rigidity in the third case) can be named, without pathologising the person because of their disposition. This seems to be often the case in psychoanalytic language and in the way of talking about personality disorders. For me, at least, a lecture or book by a renown psychoanalyst as Otto F. Kernberg gives me the uneasy feeling that "personality disordered persons" are charged with a serious moral flaw, being actually socially abominable subjects which have to be "convicted" like criminals for their perverse psychological functioning and to "uncover" their malignant soul contents by dissecting cuts. Less to the wording, but in spirit, such an attitude then is transferred naturally to all phenomena that in old Freudian tradition can not be anything than morbid: this includes all the paranormal and spiritual experience patterns. However, what for the psychoanalyst is a disease for the spiritual man is an experience of a different kind of reality. By psychoanalysis of course it is never admitted, that these difference come from ideological position, but it is claimed, inadequately reflecting the principles, the alleged scientific nature of one's own position. This applies, however, to the whole traditional psychopathology and its treatment of personality disorders, not only to psychoanalysis.

If we regard schizotypy as a dysfunctional, situationally inflexible personality type, which causes suffering and therefore (and not because of its deviation from a statistical norm!) is pathological, then the question on cause and effect has to be raised anew. Schizotypy then can be considered as the ground on which spiritual phenomena grow, or it can arise from spiritual experiences itself. The latter line of thought would understand schizotypy as an ongoing, crystallized (as having become part of the personality) form of a spiritual crisis. But why should a spiritual crisis become chronic? If we take a spiritual crisis as a potentially positive impetus (as transpersonal psychology does, cf. Grof & Grof, 1989), then it is rather unlikely that mental disorders will develop from it, unless other pathogenic factors steer that impulse into an unfavourable direction. It is well known that an internal factor promoting a negative course of a spiritual crisis decisively is the extent of the narcissistic charge of the spiritual experience. CG Jung calls this aptly ego-inflation. Ego-inflation plays often a psychodynamic part in the genesis of a spiritual experience: the chronically weak, but also acutely destabilized ego having collapsed, it finds healing in the spiritual experience, but succumbs, however, as a compensation for the previous loss of a stable Ego – to the Ego supporting error having become a special, saintly person.

Apart from the internal dynamics of the person, we also must direct our attention to the interaction of these internal dynamics with external, situational or social factors. We should remember that in shamanistic cultures the experiences of a shaman's vocation contains the danger to become mentally ill, if this is not followed. But this is often difficult in our culture. Therefore the overall social context, the setting, in which people

make spiritual experience, influence the development of these experiences and a possibly subsequent pathology significantly. These include macro structures such as the social attitude towards spirituality in general and especially to the specific experiences of the individual, but also mesostructures such as the ability to obtain competent professional help, as well as micro-structures with regard to reactions of partners, family and friends. The following case study shall illustrate these factors in the process of development of a "hyper-permeable Ego-structure" in the spiritual versus pathological direction. It should demonstrate that the development of a schizotypic disorders can be regarded as the result of a predisposition for the sensory experience type (see above), subsequent strong spiritual experience, and a lack of their integration in the social context.

Case example: Matthew A.

Matthew A.[2] (age: mid 40) describes a childhood that was marked by conflicts between an emotionally cold and punitive father (an engineer) and an exuberant warm, soft-hearted mother (secretary). Externally, the family relationships were well organized - West German town house atmosphere. Already in elementary school he sought refuge in the countryside, where he felt safe and in some cases quite "one with everything." At this point, or perhaps even earlier he had anticipated things which happened later (precognition), or he saw something that had not taken place where he was (remote viewing).[3] Unfortunately, he could not talk to anyone about it because his father was not able to understand it and his mother appeared to him rather weak. Therefore, he felt increasingly alone and got difficulties in school. He had to change to a lower level type of school and barely passed his graduation. He then immediately left home, organized his life alone and after a period of orientation took a training in a technical career.

At around 30, he married and had a son (some years later, he was divorced). The older he got the more obsessive became the intrusions of another world. At that point he sometimes felt as if deactivated and suddenly found himself in a different place or world while his body remained at a pedestrian crossing or was sitting at work. This ultimately led to an increasing disability to work, and finally forced him to give up his job. For a long time he did not know how to deal with the increasingly drifting away. Finally he found a psychotherapist interested in spiritual issues. This specialist encouraged him to go to a centre in which shamans are trained. According to Matthew A. this centre was his salvation, because he now learned to understand his altered states of consciousness as a talent and to deal actively with them.

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[2] Name and some biographic details have been alienated due to privacy protection.

[3] It is not the place here to objectify in detail the correctness of these experiences in order to qualify them as paranormal or hallucinatory. This article is written under the premise of the axiom of transcendence, which implies the existence of extrasensory perception as a possibility. From a personal, later encounter with "Matthew A." however, there is evidence for the paranormal, not hallucinatory character of his early experiences.

Psychopathological assessment

The existence of schizotypy in the example client Matthew B. may be examined under the criteria of the ICD-10 (WHO, 1993) (the text of the ICD criteria has been cited in quotation marks): The affect of Matthew B. is not "inadequate" and "cold", but "restricted", introverted, kind of "inaccessible", although he also acts very sensitive and empathetic. Because he communicates with spirits or makes out of body experiences and then sinks into himself for a few seconds or minutes, his behaviour, but not his "appearance" in comparison to the norms of society seems "odd, eccentric or peculiar". Matthew B. does not really have "few social contacts", which, however, are exclusively limited to the family and peers from the esoteric/healing scene. In contrast to the main stream of society (but not to shamanistic subculture), he believes in and lives in a spiritual *unus mundus*, where things happen in a different way, unlike the scientific laws. This corresponds closely to the "odd beliefs and magical thinking that influence behaviour" mentioned by the ICD. A fundamental distrust of social forces and persons who seek to suppress other individuals (= "paranoid ideas") is existent. Although "obsessive ruminations" may sometimes occur, most the time he is occupied with sensing into himself, observing others and nature as well as practicing shamanic activities, which can not really be called rumination. Also, the contents of his reflections are not typical (dysmorphophobics, sexual and aggressive"). "Unusual perceptual experiences with body numbness and other illusions, depersonalization or derealization experience", he presents often in the form of out-of-body experiences, (originally involuntary) shamanic trance journeys, and feelings of unreality towards our shared reality. Thinking and language are quite "vague", often "cumbersome, metaphorically", perhaps "strange", but "without incoherence", and never "contrived, stereotypical". "Occasional temporary quasi-psychotic episodes with intense illusions, auditory or other hallucinations and delusional-like ideas" demanded by ICD are not necessarily the same as seeing the aura and spirits, of which Matthew A. reports, but they would be probably included in this category by a traditional Psychopathologist.

Matthew A. clearly fulfils four criteria and perhaps meets five criteria of schizotypy. If diagnosed in a traditional psychopathological manner, Mr. A. must certainly be called schizotypal. In fact, the differential diagnosis of schizophrenia should be considered, too. This, however, is precisely the beginning of the actual work of transpersonal psychology: Let us turn from the classical diagnosing to a transpersonal perspective, then the pathological characteristics of schizotypy appear delineated from the spiritual ones. We then would distinguish the contents of Matthew A's *experiences* as transcendental from the cognitive and emotional patterns causing him problems as stable, in many situations inadequate interactions and functioning, which are therefore a persistent chronic personalization of interaction problems, that is: a psychological dysfunction. These personality elements, however, with respect to his biography do not appear to us as random in the context of his spiritual experiences, and certainly are not biologically determined. This becomes clear on closer inspection:

The dissociative experiences, Matthew A. describes strongly correspond to the pattern of journeys typical for shamans around the world (see Halifax in 1984, and Eliade, 1975), which does not speak against, but precisely for their authenticity and originality. Matthew A. appears in conversations fully conscious most of the time in terms of a non-dissociated, present consciousness. In many conversational sequences he thinks logically coherent, but sometimes volatile. He seems to strive for sorting intruding perceptions and to seek consciously an inner focus and intuitive source: He makes long pauses before answering and senses into himself. The more he gets to this core, the clearer appear his utterances. If he is pushed into a corner by questions or if topics connected with an exceptional experience are touched, he quickly becomes confused and his comments get a bit metaphorical, even incomprehensible. Sometimes it is quite unclear whether he is talking about an earthly or unearthly dimension of experience. He also sometimes uses words in a peculiar, very non-conventional sense, especially "esoteric" concepts, which he applies to everyday situations and people.

Verbally, he seems to *confound* the levels of this and a different reality like he seems to *change* them in his state of consciousness. The verbal confusion reminds of people who were alone as children or adolescents and consequently, also as adults, left to their own devices with their turbulent inner life. Especially if they had aversive experiences with telling their experience, they are afraid to talk about them in the future, and thus become vague and evasive. Moreover, they lack the capacity, acquired through the communication with attachment figures to order and sort their own introspection. For Matthew A. precisely those areas of verbalization are difficult to access that relate to the experience of "other worlds", while in other subjects he is clear and judgmentally certain. The permanent effort by the defence whether to verbalize something that he certainly experienced subjectively, nor even to be allowed to experience it at all, did not only lead to very vague language constructions, but also causes *the other*, paradoxically, to intrude in his thinking and talking even more. His esoteric language appears, therefore as an attempt to acquire a vocabulary of his own experience of the world, which, however, in the context of the society's norms seems "crazy", since there are no socially accepted ways of talking about other worlds.

When Matthew A. changes the spheres and "dissociates", according to traditional Western psychopathology, we are dealing with a case of doubtless pathological character, but in the opinion of the world's primordial religion of shamanism, however, only one thing is pathological, i.e., the fact that Matthew A. could not control his travels to the Otherworld for a long time. In any still functioning traditional culture, he would have been trained at the first sign of such difficulties as a shaman thus enabling him to gain control over his trances (see Halifax, 1984). He would have travelled together with his teachers, rather than to be send by a superhuman force to other worlds and left alone with it there. Prior to visiting the "shaman-centre" (the quality of which is not an issue here), no one taught him how to return from there, how to control the urge to change the spheres of reality or to travel within our middle world without his body. No one taught him to deal with the dangers of such trips, encountering other classes of beings there.

From the perspective of shamanism, he was thrown into spiritual danger, for which there is no coping patterns in our society.

As a result, he got more and more into conflict with his social environment. Matthew A. failed to social reality, because his spiritual reality had no place in it. If he had been understood in his otherness, would he have developed "paranoid" ideas about a society being hostile to him? Had it been necessary, that his affections developed somehow unapproachable, although he naturally possesses sociability and empathy? Has he ever had a chance to find close friends and social contacts, when in our world from the beginning he had to be considered strange? It appears that Matthew A's early in childhood beginning spiritual experience was a factor that collided with the social construction of reality and determined reactively his personal development. His reaction mechanisms are sufficiently comprehensible and, together with his primary spiritual experience form the image of a schizotypal disorder.

Conclusions

Matthew A. can describe experiences that must be accepted by an ideologically unbiased perspective as potential realities. No one can prove with convincing arguments the unreality of such experience patterns that are considered by many people in many cultures of this earth as unusual maybe, but "normal" and which are, even in our culture, not singular (see Hardy, 1979). So it is a ideological opinion, not the application of Enlightened reason if Matthew A's extraordinary experiences are considered per se as pathological. Where this happens, however, the circular argument is perfect that it must be a mental disorder (e.g., schizotypy), simply because an extraordinary experience had occurred. However, there is strong evidence that the spiritual experience of Matthew A. not by itself but only in combination with other (environmental) conditions could become pathogenic.

The behaviour problems, Matthew A. undoubtedly presents, are plausibly explained as the result of a biography of oppression of essential experience areas. From a psychological perspective, it is easy to understand, without special additional assumptions, even without that of a biological vulnerability, that a "pneumophobic" (fearing the spiritual) society (at the micro level of caregivers and peers) from the experience of spiritual and exceptional phenomena can form a disordered behaviour like schizotypy. Schizotypy may therefore most likely be the result of a lack of social and thus failed personal integration of spiritual experience.

Because of the reported case, a typical reificating perspective on the psychopathological construct of schizotypal disorders can be rejected: namely the assumption that it was simply a biological (e.g., genetic) conditional preliminary form of schizophrenia, which left untreated lead to this. It seems rather likely that we are dealing with a partly innate, partly biographically acquired predisposition to certain states of consciousness,

which is accompanied by a weakening of the strength of ego boundaries typical in our culture. If this weakening can be counterbalanced culturally or therapeutically - that is, sometimes: by spiritual or transpersonal health professionals -, the chance for a normal development, integrating exceptional experiences, should be good. Otherwise, the irruption of the paranormal, numinous will not be sufficiently integrated into the Ego structure and leads to a lack of social integration, disorders of thought and communication and thus to the clinical picture, known as schizotypal disorder. In these cases, the schizotypal disorder thus appears as an expression of a failed spiritual and personal development, of non-integrated spiritual gifts, which should be treated by dealing with the underlying sensitivities and not by the suppression of this experience through unnecessary pathologization.

Professionals advisers for people with extraordinary experiences often meet clients acting strangely or presenting the whole of a schizotypal disorder. Then, the critical and unbiased mind should be willing to ask the question of cause and effect. Are people strange because they were not able to integrate unusual experiences, or do they tell exceptional experiences because they are curious (in a sense of causality or implication)? Even if according to Jackson (1997) – like in the case of Matthew A. – a common ground as a predisposition exists that would in some cases produce both "strange behaviour" and "extraordinary experience", this must not lead into a pronounced pathology, if the social context provided adequate opportunities to integrate exceptional experience so far that even "peculiar" people with spiritual experience can not slide in pathological behaviour patterns. However, only a few institutions can give competent advice. Because of frustrating experiences, many do not look for sympathetic and helpful consultants at all and instead get caught up ever deeper in their secondary eccentricity.

However, the attitude of many traditionally oriented psychological/psychiatric clinicians to reify psychopathological constructs and look to the occurrence of spiritual experience under the "medical model", with or without other symptoms, as an expression of a disease entity as an autonomous running pathomechanism, is of no help at all. The resulting negative appraisel of the purely descriptive diagnosis "schizotypy" in the sense of genuine derangement probably can only be met by non-application in cases of extraordinary spiritual experience, as a precaution. We only can hope that cases like that of Matthew A. will increasingly belong to the past in this century of general opening. It is up to a transpersonal / transcendental psychology to ensure that such openness leads to alternative pragmatic strategies for the clinical practitioner.

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About the author:

E. W. Harnack holds a University degree in psychology and works as a licensed psychotherapist, certified clinical supervisor and independent scholar in Berlin, Germany.

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