Johns Hopkins University Press Podcast

Clara Humpston, *Philosophy, Psychiatry, and Psychology*

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Mary Alice Yeskey

Welcome to the Hopkins Press podcast. I'm Mary Alice Yeskey with the Hopkins Press Journals division. Joining us this week is Dr. Clara Humpston. Dr. Humpston is an assistant professor in Mental Health at the University of York and honorary research fellow at the Institute of Mental Health University of Birmingham, both in the United Kingdom. Her research interests and experience span from psychopharmacology to cognitive neuropsychiatry to phenomenological psychopathology. She is a strong proponent of inter and multidisciplinary approaches and values the importance of multiple lines of scientific inquiry in mental health research. Dr. Humpston's latest paper, "Isolated by Oneself: Ontologically Impossible Experiences in Schizophrenia," was published in the latest issue of the journal *Philosophy Psychiatry and Psychology*. She joined us to discuss the theories of her research and its practical implications.

Thank you so much for joining us today, Clara. I'm so looking forward to talking to you.

Clara Humpston

Thank you.

Mary Alice Yeskey

The first question we like to ask all of our guests is can you tell us what your academic origin story is? How did you come to study psychology and focus on schizophrenia specifically?

Clara Humpston

So, it's just it's a bit of a long-winded story, because when I was very young, I think about secondary school, kind of high school age of doing University applications, that kind of age, I started to wonder about the kind of nature of self and reality, kind of the truthfulness or the lack thereof of our own thoughts. How do we become certain that our thoughts, the thoughts we think every day in our heads, are actually ours? And it became a kind of a morbid fascination in the sense that I was tirelessly looking into different psychological disorders and at the time as well I was doing what is called a-level psychology. So, it's like a senior kind of high school equivalent course in psychology, and we learned a lot about schizophrenia, depression, anxiety disorders, and none of it kind of stood out to me as much as the certain symptoms in schizophrenia did.

So, also combined with the fact that at the time I was very keen to look into this further thinking, to myself, really, how do I know this thought is mine? Really bizarre, almost obsessive kind of fascination with the agency and ownership of thought, and then I looked up the

treatment for schizophrenia and related psychosis, and that was even more fascinating because at the time, I'm still a massive chemistry nut, so I was fascinated by chemistry, by pharmacology, neurochemistry, different kinds of dopaminergic pathways. So, my first kind of training opportunity arised, or kind of when I was just after my high school, to do pharmacology at the University of Bristol. That institution was very focused on kind of psychopharmacology and psychiatric medications, and I enjoyed it, and I thought: drugs are not the only answer, clearly. I mean, medications are exceptionally effective, but they're not the be all end all so I thought, I want to look into a bit more in the psychiatric side kind of research methodology. That's what drove me to do a master's degree in psychiatric research methods at the Institute of Psychiatry at King's College London.

So, that gave me a more rounded understanding, and at the same time, my fascination about agency ownership and self and thoughts, that was still there, all this way after my pharmacology training and my master's so I thought, I'd like to actually work with people who are affected by psychosis and schizophrenia, and that's what I did for my Ph.D. which was a project, well I did multiple studies, but was focused on kind of first-episode psychosis and individuals' experiences and their learning and memory mechanisms. So, it's been well, I'd say it's been 10 years since I graduated from my pharmacology degree and since then, I think I'm still fascinated about agency, I'm not sure about thought. I can't, with any confidence say that that understanding or the lack of understanding has kind of moved me forwards in the sense of I know what this is now? I can't say that, right. That is why, partially at least, I wrote a paper in the PPP. That's also why I'm still, still really, really keen to learn more about why we are so certain. Why we just take everything for granted. Why do most people never ever wonder doubt, question what they're thinking is yours, is theirs? Yeah, so that's a bit of a long story.

Mary Alice Yeskey

No, it's a great story. And I would venture to say, I mean, I think that it's really a wonderful thing that after 10 years, you're still so curious and still so, like, still really into the subject matter. You know, some people get sort of burnt out on whatever it is they want to study, and you seem to be just as enthralled as you were in high school.

Clara Humpston

Yeah, I must have been about 16-17 years old when this all started.

Mary Alice Yeskey

Yeah, and it really is kind of an unanswerable question. So, I think that that also just leaves it to never, it's never like, you close the book, and you say, okay, I'm done. Now I've learned.

Clara Humpston

No, you can't. Yeah, absolutely.

Mary Alice Yeskey

That's fantastic. So, bringing us to your paper in PPP, which is titled “Isolated by Oneself: Ontologically Impossible Experiences in Schizophrenia,” it explores ways that clinicians perceive the experiences of those with schizophrenia. For our listeners, who might not have a deep understanding of some of the psychological concepts that you discuss, can you help us understand what ontologically impossible experiences are?

Clara Humpston

So, I'll start with an example. So, for example, some patients with schizophrenia would report to their clinician that things like quite concretized I would call them delusions, but that's up for debate. Slight detour is that I don't necessarily think that all delusions are beliefs. They can just be thoughts or experiences or even carry some sort of semi-sensory quality as well. I've written about this too, and what I termed delusions are more of the kind of thinking or thoughts or experiences, sometimes beliefs that are at odds with everybody else. They must be true. So, there's a kind of interpersonal and intentional kind of disconnect between what, for example, a patient with schizophrenia perceives to be true, or real, and what society, everybody else, perceives to be real. So, an ontologically impossible experience is, for example, the thought or the experience that the whole planet Earth is contained within my heart. Or when I blink my eye, the earth will explode or when I blink my eye, I feel some sort of expansion of dimensions around me. So, in summary, they're the kind of experiences that defy common sensical logic, and defy corporality, temporality, and physicality. So, they directly go against the laws of physics.

Mary Alice Yeskey

Oh, okay. Okay.

Clara Humpston

And that's what was meant by ontologically impossible. There’s no way anything like that, or whatever exists in a common sensical and sort of culturally socially accepted world.

Mary Alice Yeskey

Okay. So, it's not just that if you have someone having that experience, and another person who isn't, it isn't something as simple as, like, saying, I have a headache, you can't see that headache, but I'm experiencing it and that makes it real. It's really sort of a bigger leap to what I'm experiencing I can't even describe to you.

Clara Humpston

That’s right.

Mary Alice Yeskey

Okay. Okay, that makes sense.

Clara Humpston

It can't be described. Well, I try to describe them.

Mary Alice Yeskey

You just did very well, but I understand the difference, yeah.

Clara Humpston

Yeah, there's a difference. It's not like the kind of what's called kind of the "veil of perception" where another person's perspective is always distant and somehow removed from one's own.

Mary Alice Yeskey

Right.

Clara Humpston

It's more of a case that whatever it is, it's just not possible by any means to be anywhere near what we perceive with reality.

Mary Alice Yeskey

Got it. Got it, because even if you can't see my headache, you had a headache and you know what that is.

Clara Humpston

Yeah, or you know headaches actually exist. I'll be, like, saying my head aches. I have headaches because my brain has been replaced by a radio.

Mary Alice Yeskey

Okay, there you go. That's not something I can understand.

Clara Humpston

You can't understand that, and you can't necessarily feel it, even if you have headaches.

Mary Alice Yeskey

Right, right.

Clara Humpston

You can imagine a headache, you can perhaps potentially empathize with it if you had it before. But you can't imagine what it's like to have a radio in your head.

Mary Alice Yeskey

Right. Exactly. That really helps. That example really helps.

Clara Humpston

Thank you. I think a lot of the patients mean it physically as well. It's not an analogy. It's not thinking that I hear voices for example, therefore, it sounds as if there is a radio in my head. It's very actual: there is a radio in my head, my brain has been replaced by a radio.

Mary Alice Yeskey

You note in your paper that the act of observing and diagnosing an experience by a clinician by making the patient aware of it reveals the impossibility of their experience, which in turn erodes the experience, which I thought was just such an interesting concept, and again, I was trying to sort of imagine this as an example in my own life and frame it in a way that I can understand in my experience. So, the way I sort of started to think about it was if you were sitting in an orchestra performance, and someone said just count the beats like don't listen to the instruments, just count the beats and how that would sort of suck you away from what's actually happening and the joy and the emotion of the experience and box it in. Is that like an accurate metaphor in terms of the way the observation and stating of the of the symptoms, sort of completely shifts and can sometimes even, like you said, erode or negate the symptoms to that to the person suffering from them?

Clara Humpston

I think that's half of the story.

Mary Alice Yeskey

Okay.

Clara Humpston

I think it's twofold because, for example, if you think you're kind of intensely focusing on one thing and ignore the rest, count the beats and ignore the whole orchestra, and that is one way of kind of interpreting the act the very act of observation on your own understanding of another person's experience. Because I think what I meant was that the first kind of aspect is the personal or interpersonal aspects of the clinician talking to the patient and the patient reporting symptoms, whatever they mean, back to the clinician, and then there's a wider angle of what is socially and culturally acceptable. So, for example, if a patient said, planet Earth exists within my stomach, or my heart, or my brain, by just fixating on this particular symptom, or experience or report, first thing that'll do is that the clinician in most cases, would just say that's a delusional belief. It doesn't happen, just simply is ontologically impossible. It can't possibly be true. And then the patient will say, I feel it in my stomach. It's very real to me. It's absolutely 100% real, and so that, by erosional experience, that kind of comes from the friction between two perspectives. Only one is actually true. I've argued time and time again that not just patients with schizophrenia, anyone can make mistakes about what is true in terms of true

social reality. I didn't say personal reality. I said social reality, but nobody can make mistakes about what is real to the person.

Mary Alice Yeskey

Very good point, amen. Amen to that.

Clara Humpston

So, everything we experience are real to us, but by someone else saying, oh, I know it's real but it's only real to you. I said that writing my paper as well. That often highlights the fact that it's not real to the clinician. It's not real to everybody else in the whole world apart from you, and to that, and it's very isolating. It's very kind of alienating to the patients because I think the clinician thinks that they are trying to help the patient by trying to understand what they are experiencing by saying, I know, it's very frightening. I know it's very real, but only for you.

Mary Alice Yeskey

Right, right. Yeah, and I'm really glad you said that. That was actually my next question because I think the part of your paper that struck me the most was that part where you sort of quoted the clinician saying, and I could hear that, you know, the therapist in my head voice: I know it's real to you. And this is very sort of, you know, patronizing tone, but, and you noted in your paper that comments like that, like you just said exacerbate their solitude, and that this was the part I was really struck by, clinicians will never understand because striving to understand is the wrong goal. So, I just was wondering if you could speak more on that. So, what is the goal? Because, like you said, I think when a clinician says that they think they're being empathetic, but like you just stated all it's doing is driving that wedge between experience A and experience B more, like, I know it's real to you does not make that person feel better. So, can you speak more to that like, what would you propose the goal is then?

Clara Humpston

Oh, gosh, that's a big question.

Mary Alice Yeskey

Can you explain that in five minutes? (laughs)

Clara Humpston

No, probably 50 hours (laughs). I think it depends on the person. I'm a massive fan of personalized individual based care and treatment because for each person affected with schizophrenia or other psychosis and mental illness, what this what this particular person wants in life is again, different, if not the opposite to someone else. For example, one person might think that my feelings of Earth existing in my stomach are a direct result of dopamine dysfunction. Another person might think it's a mystical experience, and I quite like this feeling

of kind of encompassing the Earth, this kind of feeling one with the universe that I'm feeling whereas another person might be heavily distressed and might do something risky to get Earth out of themselves that kind of very harmful behavior as well. So, I think the goal really always--a cop-out answer--but I think, really the goal of any sort of therapeutic alliance depends on exclusively the patient or the client to achieve this sort of mutual understanding is not the only goal. Obviously, sometimes in people with less ontologically impossible feelings. So, things like feeling that they are being persecuted or someone's following me or somebody's spying at my Twitter feed or that type of thing. That is more ontologically possible, if you want to flip it on its head because sometimes people do that type of thing. I'm being stalked or you know, nasty things people do. But in that sense, you can have an unusual understanding.

Mary Alice Yeskey

Right.

Clara Humpston

For example, the therapist might have had a similar experience themselves. But when it comes to if we can talk about it a bit more is the whole concept of schizophrenia. In my mind, I think it's in one of my responses to one of the commentaries on this particular paper. I said, I think the whole concept of schizophrenia has been narrowed and not broadened. It's just my own view, because if you think about the essence, if you use it loosely, the essence of schizophrenia to me is paradox. It's ontological impossibility, but things that are ontologically impossible, but they are possible within the patient's mind, and then the patient's mind they still are part of the wider world reality. So you can think about such experiences existing in a human mind that they must be real they must be true as well because, hey, my mind is part of Earth. This, I say, consciousness, well I'm getting grand now, consciousness kind of exists within the world, but it's also our world because you can't perceive anything without being conscious. That's what I mean. It's sort of like, I also use the Mobius strip analogy in my paper, if infinity is going back and forth, back and forth, coming back to the goal. I think, if there has to be one universal goal is that if the patient is willing and accepting of such a solution, I call it a solution but it's not really, for everyone, is to – I said this in my paper - to cut the strip, the Mobius strip, cut the ribbon from an external point of view, even just temporarily, so that the patient can be, I said empowered, and be shown the way they could walk up rather than just being told that this is my reality, and that's yours. You have to conform to societal reality or your personal reality. I know it's real to you by the way, but it doesn't count. I think that to have the choice of what kind of life I want to lead to have the optional, some sort of pathway where you can choose willingly to walk along this side or the other side knowing both would be accepting of you. I think that's really empowering.

Mary Alice Yeskey

Yeah, without the judgment and value point, yeah, one versus the other. Right, right.

Clara Humpston

Obviously, you have to emphasize that this is all a bit idealistic because sometimes there are risks, dangers, and questionable behaviors involved in major mental illnesses. So, as long as there's no direct threat to yourself, or to other people, no risk to lie to property or any sort of illegal criminal kind of aspect. Forensic aspect of this kind, it's rare, obviously. I'm not at all saying that it's the inevitable consequence. But sometimes it does happen.

Mary Alice Yeskey

But yeah, that would be the difference between someone who is choosing and versus someone whose behaviors or actions are harming themselves or other people.

Clara Humpston

That's right. Yeah, as long as the latter is not present, or at least can be managed. Yeah. I think, who are we to judge?

Mary Alice Yeskey

Exactly. Yeah. I'm intrigued by that, and you also had noted in your paper that, again, just sort of tying into what you just said that, that clinicians and patients might be better served by not trying to remove the experiences entirely but aiming for temporarily removing those experiences, and I was curious about that in terms of sort of tangibly how that happens. Is that something that would like medication that's happening every once in a while? How does one temporarily remove these experiences? Does it even exist? Does that happen now?

Clara Humpston

I think it can happen, especially in the first episode of psychosis, which may or may not lead to a diagnosis of schizophrenia, by using some kind of relatively relative and it again, depends on the person because each person's biology, physiology, chemistry are different. So, for example, low-dose anti-psychotics can just give this individual a moment of clarity, and then that carries a risk by itself, in the sense that because the societal reality is still very judgmental, by realizing that Oh, for the last, I don't know, two months, three months, half a year, I've been living a lie I've been living in this. It's just made some sort of delusional dreamland. I just came to the realization that none of it was actually real, which it was, but because things like by what clinicians say like I know it's real, but it's not real for everyone else that this after the diagnosis of post-schizophrenia depression as well.

Mary Alice Yeskey

Oh, interesting.

Clara Humpston

At least in the ICD, I think, not sure about the latest version, as far as I know, at least once has been diagnosis of kind of post-schizophrenia depression, and that gaining of insights which I brought up in my paper as well, there's some clinicians are very keen to impose on the patient for them to really snap out of it and think, oh, yeah, I can re-integrate into the wider social reality now. Well, that can do more harm than good because if you're plunged into the social reality, or just picked up from yours, and just dumped in the community without any follow up care, which happens, and then just left to your own devices, that's incredibly kind of alienating and just isolating for the individual as well. Because they have no other option, but to live like a normal human being, quote, unquote.

Mary Alice Yeskey

Yeah. Air quotes.

Clara Humpston

Yeah, so I would say, a small kind of insight for the stages after psychosis that can carry risk of suicide, thoughts, even behaviors, attempts, even completely suicide sometimes because the individual is so far removed, not temporarily removed, but so far removed from their own reality and they have no choice because sometimes, as I was saying earlier, if you can have the choice of staying in my reality or gradually merging towards the social shared reality, then that's better. At least I made the decision rather than being dumped in, as I said before, in the social reality without any way back. So again, I think I would like to take an individualized approach. Focus on the individual, what that particular person wants at this moment in life.

Mary Alice Yeskey

That makes sense, and I'm struck by what you said about sort of the post-schizophrenic experience, you know, and how there would be such a deep sense of mourning, if someone was perfectly fine where they were and then were just told actually, I mean, it's almost like The Matrix. It's like actually, no, this is not right. That's given me a lot to think about.

Clara Humpston

I mean, I don't know if you're familiar with some of--this is shameless self-advertisement (laughs).

Mary Alice Yeskey

That's okay. That’s what we’re here for (laughs).

Clara Humpston

My brilliant Ph.D. student, Rosa, myself, and Professor Matthew Broome, wrote this paper in the *BJ Psych Bulletin* last year, I think, it's called “Finding meaning in Disorder,” and because Rose is a consultant psychiatrist in the National Health service, and she has encountered a lot of

acutely psychotic first episode individuals, and one of them said he was the happiest person in the world in his delusional stage, and then, after the clinical encounter, he wasn't the happiest person in the world anymore (laughs).

Mary Alice Yeskey

Right, right. He was not better off. Do no harm wasn't quite followed, right.

Clara Humpston

No, no, it's not Rose's fault.

Mary Alice Yeskey

Oh, no, no, I wasn't implying that. I'm just saying like you said, it's like the veil is lifted, and there's like a there's like a reckoning.

Clara Humpston

It's a reckoning. It's a sharp kind of unrelenting, undeniable reckoning that impacts your whole human being.

Mary Alice Yeskey

Yeah, yeah, there's no escape from that.

Clara Humpston

No, no.

Mary Alice Yeskey

What are you researching now? What's next for you? Do you have any research that's happening that you'd like to share with us?

Clara Humpston

Yeah, cool. So, I just, I've been kind of nominated by my institution for what is called the Springboard Award, which is for newly kind of appointed lecturers, assistant professors in the field of biomedical science. So for this one, it's only a two-year relatively short grant. I'm applying for a study of non-clinical hallucinations and self-experiences in relation to how we can potentially change or manipulate or influence the feelings of disembodiment in individuals who are quite prone to hallucinations and senses of loss of self or lack of coherence by using brain stimulation.

Mary Alice Yeskey

Interesting.

Clara Humpston

And also trying to figure out what makes an individual non-clinical and what pushes an individual over the line to first-ever psychosis, that type of differentiation between clinical presentation and clinical outcome, so that's one thing. Another thing, so I recently applied for a fellowship where I would look into the kind of relationships between cognitive intrusions that may or may not in an individual encompass ontologically impossible experiences, for example, thought-insertion, command hallucinations, that kind of experiences and how they might affect the individual to such a degree that they think about suicide. So, by using experienced sampling method, so we would have a snapshot or some sort of, I say monitoring, it's basically being asked your word, kind of a full-on capture of the daily fluctuations in cognitive intrusions and suicidal thoughts. That's the two projects I'm currently trying to get funding on. Other research, I think I have another paper, that's an even madder paper, all about the paradoxes in schizophrenia. I actually, just of yesterday, my brilliant Ph.D. student Rosa published a paper on delusional experiences across kind of multiple studies, so it's called "Systematic Review and Qualitative Evidence Synthesis." That was actually published The Lancet Psychiatry and that's received lots of really, really positive feedback. Yeah, I'm very proud of Rosa.

Mary Alice Yeskey

That's fantastic. Congratulations to Rosa.

Clara Humpston

Thank you.

Mary Alice Yeskey

And to you as her advisor.

Clara Humpston

Yes, I'm one of the senior authors.

Mary Alice Yeskey

Well, thank you so much, Clara, for talking with us today. This has been such an interesting and thought-provoking conversation and one that I know I will be sort of pondering and thinking about in my own mind and life, so I appreciate you taking the time to talk with us today and best of luck with the rest of your research.

Clara Humpston

Thank you very much. Let's keep in touch.