

CHAPTER 1 - TRADITIONAL AND CURRENT VIEWS ON PSYCHOSIS

This study explores the growth and healing of a patient who has suffered from psychotic episodes since her early childhood. It is argued that the phenomenological and dialogal approaches provide a solid foundation for grounding the healing process in the **relationship** formed between the therapist and the patient which is a very different stance from the traditional approach to working with psychosis. The study aims to indicate that psychosis may be healed to varying degrees when the patient is simply met and heard in a climate of respect and trust. The growth to a more cohesive sense of self and integration and the lessening of psychotic symptomatology is shown to be primarily due to the psychotherapeutic relationship. An overview of the traditional and current views of the mentally ill and psychosis is provided in this chapter.

ATTITUDES AND APPROACHES TO THE MENTALLY ILL IN THE WEST THROUGH THE AGES:

Psychosis has been an element of human existence since time immemorial. Various attitudes and approaches to psychopathology and treatment, or the lack thereof, have differed according to society's prevalent beliefs and philosophical views. Cushman (1992) states that psychotherapeutic theory and practice are "social artifacts and as such both reflect and shape the configuration of the self and the illnesses of their era" (p. 34).

The stages discussed below do not end abruptly but overlap and blend into each other.

1. The Middle Ages.

The truth of Cushman's statement has been clearly demonstrated across the centuries. There are varying reports of how disturbed people were treated in the Middle Ages in Western Europe. Ellenberger (1974) states that there were institutions for the mentally sick but there is little information as to what the conditions of these institutions were like. There are some descriptions indicating that the mentally ill led a marginal life, living off charity, being ridiculed but also being allowed to tell the truth to anyone. In the thirteenth to fifteenth centuries, the Islamic world treated the mentally ill with more consideration and some luxurious hospitals were built. Spain followed the example by creating better facilities and laws for the treatment of the insane. However, the contrast of other mental institutions, where people were chained to the walls and barely fed, highlighted that society was still uncertain as to how to treat those who did not conform to social norms.

2. The Renaissance.

The Renaissance began in Italy in the fourteenth century but only spread through Western Europe in the sixteenth to seventeenth centuries. Michelet (Microsoft Encyclopedia, 1993 - 1996) refers to this period as the time when there was a discovery of the world and of man. The great Swiss historian, Jakob Burckhardt, characterised the Renaissance as nothing less than the birth of modern humanity and consciousness after a long period of decay. The contrasts displayed in the Middle Ages were also to be seen during this period. It was a time of great suffering for the mentally ill and non-conformists. For example, slavery was re-established and witch hunts increased. The

number of asylums built in Spain were few. However, in the sixteenth century, Juan Duarte, who had been hospitalised for an acute psychotic episode, founded an organisation that was to build many institutions where people were treated humanely. These institutions were built in Spain, Italy, France and other countries. Ellenberger (1974) states that a negative feature of the Renaissance was its "contempt for the vulgar, the illiterate, and the fool" (p. 15).

Dreyfus and Rabinow (1983) analyse Foucault's views in their article "Michel Foucault: Beyond Structuralism and Hermeneutics". In Madness and Civilisation (1965), Foucault portrays the mental asylums of the seventeenth century as grim and gruesome places. Originating in the middle ages as institutions for the confinement and care of lepers, these structures were subsequently used to house many social misfits in the years that followed. Foucault attributes the mass incarceration of that time to changes in how mental illness was defined by society. Luchins (1993) states that Foucault believes society was threatened by unreasonable people in an Age of Reason. In that time period, in Paris, all socially deviant and unacceptable people were confined to keep them off the streets. Thus, the mentally ill, criminals, the poor and unemployed were all incarcerated in the same institutions. Previously the poor had been banned from the cities but now they were confined within them. Dreyfus and Rabinow report that, in 1656, one percent of the Parisian population was housed in mental institutions and Foucault queries the social control factors involved in this marked increase of the socially deviant. He speaks of the contrast between madness and reason, that is the dialectic between labelling people as social deviants requiring incarceration and the religious call to care for them. Foucault submits that this social incarceration resulted in the isolation and observation of whole categories of people and was the first sign of the modern medical, psychiatric and human sciences approaches. He highlights that this was a form of social control. These type of institutions spread throughout France and Western Europe and were utilised for the above purposes until the French Revolution.

Foucault believes that it was after the revolution that society's current approach to madness emerged. At the beginning of the nineteenth century, many people were enraged that the mentally ill had been confined with criminals. This was not necessarily a humane response but rather a social response of the upper class criminal element who reacted negatively to being confined with people they perceived as their social inferiors. Foucault states that the second reason was that the poor were viewed as a powerful social resource and thus an economic factor because they could be made to work for nothing or very little. Dreyfus and Rabinow (1983) allege that if the greater sector of society, the poor and unemployed, were a potential source of the nation's wealth, then, as Foucault says, "confinement was a gross error, and an economic mistake" (p. 8). Thus, Foucault alleges that the rehabilitation and treatment of the mentally ill was a myth. These reasons highlight that society was still unable to understand and respect the world of disturbed people. The tragedy is that, as patients were deemed to be responsible for their illness, they were punished for their behaviour. Foucault says this was to make the patient aware of the responsibility of his own actions. That these occurrences were a result of societal influence is reinforced by Pinel's view that the mentally ill "must be brought back to an affirmation of social standards by a series of techniques of retraining, consciousness alteration, and

discipline of both the body and the psyche" (Dreyfus & Rabinow, 1983, p. 9).

3. The Age of Enlightenment.

In the Age of Enlightenment, in the late seventeenth and eighteenth centuries, laws were based more on the belief that good order is intrinsic to the development of greater truth, rationality and humanity. The number of mental hospitals in Western Europe increased. These were based on the models of either the prison or the monastery and Ellenberger (1974) states that the systems based on the monastery treated the mentally ill more humanely. Burckhardt's "birth of humanity" had thus not enlightened society to a deeper understanding of mental illness or mankind. Descartes and the prevalent thought in the early seventeenth century was unfortunately to set the tone for the centuries that followed. He attempted to apply the rational, inductive methods of science and mathematics to philosophy. It is hardly surprising that the objectification of human beings was further entrenched as a tenet due to this approach to philosophy. Descartes states: "In our search for the direct road to truth, we should busy ourselves with no object about which we cannot attain a certitude equal to that of the demonstration of arithmetic and geometry" (Microsoft Encyclopedia, 1993 - 1996). Apart from his desire to understand life based on a scientific approach, Descartes introduced the concept of a duality between the mind and body and man and the world. This resulted in man perceiving mind-body and man-world as separate entities and not as an indivisible whole.

In the eighteenth century, mental illness was regarded as a disease to be treated by the medical practitioner rather than the priest. The Cartesian influence and the medical model resulted in an approach in which the aim was to subdue and/or obliterate any signs of psychosis without any attempt at understanding. Within this approach, mental patients were viewed as objects to be medicated and/or hospitalised in settings which recognised little individuality and showed no respect for human dignity.

However, the Moral Treatment approach which arose towards the end of the eighteenth century offered some hope for the mentally ill. In the United States of America, Benjamin Rush introduced the concept of moral treatment at the Pennsylvania Hospital in Philadelphia and other institutions were opened based on similar principles. Rees (1957), who has been a medical superintendent at various mental hospitals in the U.S.A., describes this as a time when there was more focus on social and environmental factors as being the causes of mental illness. This was a positive change as the mentally ill were now regarded as normal people who had lost their reason due to severe psychological and social stress. Rees states that these stresses were called the "moral causes of insanity, and moral treatment aimed at relieving the patient by friendly association, internal discussion of his difficulties and the daily pursuit of purposeful activity; in other words, social therapy, individual therapy and occupational therapy" (p. 306).

The peak of Moral Treatment was reached during the years 1820 - 1860 and this approach achieved excellent results. Where there had been little or no improvement with archaic and cruel treatment, many patients improved with moral treatment. For example, in the Worcester State Hospital in the United States of America, seventy

percent of patients admitted within one year of the onset of their illness, were discharged some years later. A follow-up of these discharged patients indicated that only fifty percent had had a relapse. This figure indicates a fairly high rate of success (Bockhoven, 1963).

Rees (1957) writes that it is generally agreed that Moral Treatment declined towards the end of the nineteenth century and was at its ebb during the first two decades of the twentieth century. Rees states that this has been attributed to a number of varying developments. For example, the Industrial Revolution and mass production which led to growing materialism, the influence of Darwin as well as that of Virchow's cellular pathology. Virchow states that insanity was due to irreversible cellular changes and heredity. This is a depressing view as it removes the hope that the mentally ill can be healed by the interventions prescribed by the Moral Treatment approach. This resulted in the incarceration of many people to avoid them reproducing children who would also be mentally ill.

4. The Industrial Revolution.

The Industrial Revolution which began in Britain at the end of the eighteenth century further dehumanised and depersonalised man (Microsoft Encyclopedia, 1993 - 1996). As this industrialisation continued worldwide into the early twentieth century, technology resulted in the more efficient organisation of society, business and life, but rendered the individual man less important and merely a number in a system.

5. The nineteenth century.

Kierkegaard states that the major problem of his age was a "contempt for the individual man" (Chessik, 1986, p. 83). This attitude resulted in man becoming more isolated from his fellow man and detached from himself. Personality was viewed as consisting of fragmented aspects of the person and this carried into the twentieth century where Victorian man saw himself as separate pieces involving reason, emotion and will. This attitude was congruent with the development of industrialisation. The broader concept of reason in mental illness had become limited to techniques, specific problems, separated from emotion and will (May, 1958). For example, Beard theorised that symptoms were a result of exhaustion and a lack of "natural body electricity" (Cushman, 1992, p. 33). His treatment involved removing people from their everyday environment to reduce stress and recharging their "natural emotional energy by direct doses of electricity" (p. 33). This further entrenched the Cartesian split between mind-body and man-world.

Despite the growth of industrialisation and the attitudes of people like Beard, there were some positive moves in the nineteenth century. William Tuke allowed patients to express their agitation which resulted in the reduction of symptomatology. Pioneers such as Johann Langemann, Johann Heinroth and Karl Wilhelm Ideler, shared the belief that mental illness had emotional causes and that psychotherapy could possibly help even severe psychotics. This provided some glimmer of hope for the disturbed (Ellenberger, 1974).

6. The twentieth century.

Cushman (1992) describes man, at the turn of the century, as being "confused,

faceless ... beset by feelings of derealisation, moral confusion, and a lack of a sense of meaning and a place in society" (p. 36). This trend continued into the new century. For example, in the early part of the twentieth century John Watson and Luther Holt advocated that one did not need to meet children's emotional needs. The Holt feeding schedule, which was to set feeding patterns for babies for decades to come, was based on methods originally planned for feeding cattle. Watson advised that babies and children should never be shown physical affection. The pervasive influence of finance as a measure of power and success in Western cultures in the twentieth century has further deepened the split in man who defines himself according to his position and wealth in society rather than himself as a human being. The connectedness of self, both within and with the outside world that exists in many Eastern cultures, indicates the authenticity of living as a whole human being within the context of a family, community and society. Something that has been little understood within Western scientific thinking, especially in the increasingly materialistic twentieth century.

By the mid-twentieth century, the United States had approximately 600,000 patients in psychiatric hospitals, nearly all of them diagnosed as psychotic and over half as schizophrenic. The number of mentally ill people, including those not hospitalised, was estimated at around a million (Cameron, 1947). Accounts from various individuals in the first half of this century support the fact that attitudes to mental illness and the mind-body/man-world split were still alive and strong. Boisen (1962) describes his period in a mental institution in the early 1920's as extremely negating. The typical approach of the times is highlighted by his mention of the "organistic" approach doctors had in which illness and symptoms were simply not discussed with patients. In his first edition published in 1936, Boisen was advocating that the difficulty for many lay, not in an organic defect, but in "the disorganisation of the patient's world" (p.11). He stresses the failure of the individual to live up to society's standards and how this accepted social judgement results in a loss of self-respect and creates a sense of alienation.

Kaplan (1964) has collated a number of psychotic patients' descriptions of their experiences of mental illness. Lara Jefferson, who was hospitalised in the 1940's due to her psychosis, powerfully describes the chaotic, constrictive, objectifying and uncaring atmosphere in the mental asylum as she strove to maintain some small semblance of sanity. In speaking of the societal pressures to conform, she relates how she undoubtedly would have been accepted into society at another time and place where she would have been recognised and accepted for who she was. As she could not conform to the current societal demands, she was declared insane. The treatment, including the use of straight-jackets, led to her insight that she could "see a new place to apply the abhorrence we feel for the Chinese custom of foot binding" (p. 11). She portrays the psychiatrists as men who have "endless ideas and theories" (p. 5) and "have got us all analyzed and psycho-analyzed down to insignificant daubs of protoplasm" (p. 14). She feels that patients were not allowed to take any responsibility for themselves and that their attempts to cope with the world in a manner that suited them was completely ignored by the psychiatrists. The end result for the psychiatrists of not recognising the meaning of the insane world was the inability to make "an insane person sane" which rendered them "helpless" (p. 5) to treat effectively. Francis Farmer's (1942) shocking description of eight years in a mental asylum in the U.S.A. also highlights the dehumanisation of the mentally ill human being in that period. It is

an amazing account of the nightmare and terror which she survived before she was able to function in the world again. Cameron (1947) points out that society dooms many curable patients to a lifetime of despair and loneliness because of its inability to recognise mental illness as a natural and understandable form of illness.

The Phoenix Conference, held in the United States of America in 1985, highlights the two dominant themes present as the twentieth century drew to a close. Firstly, that "the only valid knowledge is scientific knowledge; hence human life is predictable, explainable and controllable". The second is that man must be "set free from the stunting effects of civilisation to realize itself and to actualise its highest potentials" (O'Hara, 1993, as cited in Stubbs & Bozarth, 1994, p. 109). This indicates that the scientific approach which stresses that man is an object to be studied and controlled still has a powerful influence over modern day thinking about man. Although the second theme recognises the more positive belief that man is an individual who should be allowed to be a unique person in a community or society, the dangers of objectification are still very real.

Tragically, Cushman's words about the confusion of human beings at the beginning of the twentieth century, as stated above, remain remarkably true for man as he begins the new millennium. Although we might appear to have moved far from those lunatic asylums with people in straight-jackets, subdued and controlled with medication, their influence is still strong today. With the growth in technology connecting mankind worldwide, the trend to objectify man seems even more powerful. Man's individual rights and needs are ignored in the search for greater control and management of life on this planet. Individual isolation is further heightened by this approach.

SOCIAL FACTORS:

The course and outcome of treatment for dysfunctional behaviour may differ significantly depending on sociocultural and political contexts. In some non-Western, non-industrialised societies, people recover fairly quickly and are reintegrated back into community with little, if any, residual damage to their sense of self and belonging. In the Western world people suffer from more chronic and progressive problems, often with a poorer prognosis. Corin (1990) found that re-hospitalisation was often associated with a need to be normal and fit societal norms and values. Her examples show how "contemporary Western capitalism may be as responsible for the nature of psychotic experience as for the loss of sense of self and functioning" (Davidson, 1994, p. 123). Kaplan (1964) believes that abnormal behaviour indicates a negative response to societal norms - "perhaps the most extreme and complete form of negation that is possible" (p. xi). In a workshop presented in South Africa in February 1999 by a well-known American psychologist, a cartoon was displayed which summed up Western society's current attitude. The slide depicts a doctor coming to meet the patient in a consultation room with a thick file, saying "Nice to put a face on a disease." This cartoon is a sad indictment exemplifying the lack of human interaction and caring in today's medical fields.

As indicated above, individuals who do not conform to society's norms are labelled as deviant and/or abnormal. They are harshly judged against the cultural norms of acceptable behaviour and the ability to have social relations. The need to assist human

beings to function in a world of interpersonal-relationship becomes a necessity in society, not only in psychopathology. This is emphasised by Pande (1968) when he examines the differences between the Western and Eastern cultural approaches. Western society is an individual-oriented society where work, productivity and reaching individual goals are of prime importance. Eastern cultures are more relationship-oriented and thus tend not to need psychotherapy in the same way Westerners do. Pande makes the valid statement that Western man needs to constantly be making progress towards some goal whilst daily life becomes more fragmented and split. The result is a failure to find real value and meaning in human relationships. This accentuates the isolation and withdrawal that occurs in Western society as the lack of support systems and healthy relationships create alienation and an inability to live with ambivalence.

Ironically, the Cartesian influence and the medical model created a need for psychotherapy and yet psychology remained firmly entrenched in the very concepts which had created the problem in the first place. Many schools of thought in the psychological field adhere to objectifying the patient thus looking for solutions within the framework that created the scientific, objectifying, negating approach. Basing exploration of the patient's experiencing on a scientific approach results in a narrow, limited framework which will offer few alternatives and never allow the richness of the experience to emerge. Romanyshyn (1991) describes how the scientific approach with its need for order and linear, simplistic answers, results in less meeting of man in his complexity and his soul. He believes we need to "remain twisted, soulful, in a linear world ... If, individually and culturally, we are to make myths instead of symptoms, we need to preserve the complex character of our ensouled involvement with the world" (pp. 27 - 28).

Contemporary treatment usually involves drugs and/or hospitalisation to control unwanted and unacceptable behaviour. In a world where pharmaceutical companies form major conglomerates and are a source of high income, the influence and power they yield is enormous and this both encourages easy solutions and can result in drug abuse. Ciompi, 1991 (as cited in Prouty, 1994), reports "good to satisfactory results in about two-thirds of cases" (p. xvii) where schizophrenics were treated with psychotherapy and very low dosages of neuroleptics. This suggests that medication is not always necessary and, even when it is, it does not have to be used to blunt or obliterate the patient's feelings and experiencing.

Parloff alleges that government officials, courts, insurance companies, managed health care workers and the like demand definitive answers to queries around solutions that will meet society's needs in a cost-effective and timely manner (Goldfried, 1980). The quick fix mentality of modern society also encourages supposedly instant, easy solutions and effective short-term control methods. The vast number of people requiring assistance in the mental health field adds weight and impetus to this approach. The decline in the supportive, extended family network has contributed to increasing isolation of the individual and the inability of some to cope effectively with their problems. The media, who highlight important information, can also create fads where it becomes fashionable to be on certain drugs. A good example is Prozac which is viewed in the media as the popular "personality drug". Overall the so-called quick and

easy solution approach ensures more control over socially unacceptable behaviour generally. It reduces and even negates the importance of the time and effort taken to understand and improve the patient's communication and interaction within the larger framework of society.

TRADITIONAL AND CURRENT APPROACHES TO PSYCHOPATHOLOGY:

In the psychiatric framework the meaning and function of any experience that does not conform to society is usually brushed aside or viewed with a judgemental and jaundiced eye.

Admittedly, psychological literature abounds with examples of scientific studies and this can provide one with a general overview of psychopathology and knowledge on the particular profiles which emerge. This can increase one's understanding of psychopathology but the trap is that it can also result in objectifying man and failing to view the person's individual experiencing and world thus eliminating the most basically human aspect of existence.

Psychopathology acknowledges that there can be severe disturbances in man's behaviour, thought patterns and consciousness. What is seldom recognised is that this so-called abnormal behaviour is an "exaggerated or unbalanced expression of the normal" (Noyes, 1963, p. 80). It is always possible to link the abnormal person to who he was before the need for a mental illness arose. When defences are no longer able to provide stability the adaptive abilities of the person become ineffective and disorganised. A mental disorder serves the functional purpose of protecting the individual and allowing some sense of control in an altered and isolated world. When man is labelled according to whether he is normal/abnormal or healthy/sick it immediately separates him from the everyday world. In this process symptoms are viewed as something to be removed, medicated away. This prevents one from understanding the value and role of the symptom and the need to face and respect the real experience of the patient.

CONCEPTIONS OF PSYCHOSIS:

Much of the literature on psychosis focuses on schizophrenia. Although the current study is not about someone diagnosed with schizophrenia, the patient has experienced psychotic episodes since she was a child. It is thus important to understand the prevailing views on psychosis in general.

What is perceived as concrete reality depends to a large degree on societal beliefs. We have to live with others in mutual relationship, whilst preserving some sense of self. This can result in conflict, confusion and a "flight into illness in order to escape from reality and relieve oneself of responsibility" (Jaspers, 1963, p. 387). Psychosis allows one to experience as real what "reality refuses" (p. 387) to believe.

The narrowest definition of psychosis is restricted to the presence of delusions and prominent hallucinations. The psychiatric definition of psychosis (Kaplan & Sadock, 1991) is an "inability to distinguish reality from fantasy; impaired reality testing, with creation of a new reality" (p. 218). The DSM-IV (1994) offers a broad range of definitions based on the characteristic features of the disorder to which the psychosis

is linked. For example, it provides the features and diagnostic criteria present in Brief Psychotic Disorder, Shared Psychotic Disorder as well as those disorders characterised by having psychotic symptoms as the defining feature.

Whilst definitions may provide us with broad guidelines of the concepts involved, the danger lies in the simplistic approach of accepting these as concrete facts and failing to deepen the understanding of the broader implications. Likewise, definitions provide us with superficial descriptions of behaviour without any explanation as to what it means to the individual in his context. Thus, in the psychiatric sense, the meaning of the symptom is largely ignored and simply treated to alter or eliminate it.

Two aspects of psychosis are briefly discussed as the patient in this study has experienced both these alterations of reality.

1. Hallucinations.

This is defined by Kaplan and Sadock (1991) as a "false sensory perception not associated with real external stimuli; there may or may not be a delusional interpretation of the hallucinatory experience; hallucinations indicate a psychotic disturbance only when associated with impairment in reality testing" (p. 220). The DSM-IV (1994) adds that the hallucination "has the compelling sense of reality of a true perception" (p. 767). Jaspers (1963) defines true hallucinations as "false perceptions which are not in any way distortions of real perceptions but spring up on their own as something quite new and occur simultaneously with and alongside real perceptions" (p. 66).

There are variations of hallucinatory experience such as hypnagogic and pseudo-hallucinations as well as true hallucinations as described above. Hallucinations can appear when there is disturbed consciousness due to organic reasons. For example, in head injury after motor vehicle accidents, epileptic seizures, sedation, cerebral illness/insult but, in psychosis, consciousness is considered to be clear. Auditory hallucinations are more common and result in less confusion and fear than visual hallucinations which are a greater distortion of reality (Noyes, 1963).

1.1 Pseudo-hallucinations. Sedman (1966) defines pseudo-hallucinations as false sensory perceptions which occur when a person is fully awake. They are usually fully projected into external space and are experienced as if through the sense organs. Pseudo-hallucinations are usually of human figures which are psychologically meaningful to the individual and are recognised as visions of people rather than real. It is as if they were experienced in the mind's eye. Jaspers (1963) states that the only way they differ from true hallucinations is that they are figurative, occurring in inner subjective space and not in concrete, external, objective space. They frequently have definite contours and are fully detailed but may also manifest in the form of pale, vague images. Jaspers states that there can be a transition where pseudo-hallucinations can change into true hallucinations or a state where they combine. Like the true hallucination, pseudo-hallucinations cannot be deliberately altered or evoked.

2. Delusions.

A delusion is defined by Kaplan and Sadock (1991) as a "false belief, based on incorrect inference about external reality; not consistent with patient's intelligence and

cultural background, that cannot be corrected by reasoning" (p. 219). The DSM-IV (1994) adds that the inference is "firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary" (p. 765).

One of the strongest features of delusions is that they are incapable of being altered by logic or argument which is why they can be so firmly entrenched and intractable. They then lead to errors of judgement of reality. Cameron (1947) adds to his definition on delusions stating that they "usually lead to behaviour that is socially detrimental, inappropriate or inept" (p. 390).

THE MEANING OF PSYCHOTIC BEHAVIOUR:

Van Werde states that psychotic behaviour is pre-expressive behaviour. This means that "we see such behaviour as a way of expressing meanings that are there, but not yet fully in process, nor available to the person" (Prouty, 1994, p. 96). That is, these meanings are implicit or unconscious.

In many psychological approaches psychosis is understood to be meaningful within the framework of the patient's experiencing of his world. Psychosis is related to the patient's attempt to make sense and create order out of the unmanageable aspects of his life and self. This is similar to the manner in which the child uses fantasy to control and master his universe. Fantasy is a major adaptive response for coping with reality in the life of a child. The intensity of the symptoms points to the patient's desperate need to gain some mastery over a chaotic world. In children, the role of fantasy becomes important as a way of magically mastering danger. With no effective or adaptive defences to manage the daily environment, the child can gain control by splitting and fantasising. Fantasy becomes a powerful tool as the child can people his fantasy world with the omnipotent, protective, need-satisfying characters he seeks. Winnicott (1977), in his case study of Piggie, agrees and stresses how the child can play with the fantasies that most disturb her. That is, enjoyable play allows anxiety to be mastered and contained within the total experience.

Jaspers (1963) describes reality as generally being formed within the context of its societal meaning and common understanding. Man does not have a direct, objective contact with reality and experiencing is always influenced by his subjective perceptions, emotions, hopes and fears (Noyes, 1963). Individual experiencing must therefore be tested against the general, shared reality. This becomes a difficult task when the individual's need for an altered reality arises. If the pressures and stress of life become unmanageable, the adult may revert to an extreme form of fantasy as a means of coping and distancing. Another of man's earliest defences is the ability to remove himself from reality by distancing and blanking out experience. This distancing occurs in order to avoid feeling the pain and emotional disturbance of the current experience. However, if the individual's way of life and experiencing constitutes severe or ongoing crisis and trauma, physically and/or psychically, dissociation and depersonalisation are insufficient defences. Psychosis is the most extreme manner of escaping reality.

Kruger (1988) describes how schizophrenia is an attempt to "bring a halt to the disorder of inconsistency" (p. 173). Eigen (1993) states that the sense of catastrophe

experienced in psychosis is a basic and often central fact of psychosis. In the process of disintegration the individual experiences a state of nothingness which Winnicott ascribes to a break in continuity in his experiencing of the world. For example, in this connection, Nuechterlein et al's. 1922 longitudinal study on vulnerability and stress in schizophrenia is very relevant (Prouty, 1994). It was discovered that there were a "disproportionately high frequency" of stressful, uncontrollable life events outside the client's life "in the months before psychotic exacerbations and relapses" (p. xvi). Ciompi describes acute episodes with visible psychotic symptoms as a "critical overtaxing of a vulnerable information-processing system" whereby "pathological new states of equilibrium" (p. xiii - xiv) are attained.

Schwartz, Wiggins and Spitzer (1997) detail two differences between normal and psychotic experience. The first is that the psychotic's experiences include an "expanded horizon of meaning" and secondly, that implicit meaning becomes "explicit and covert" (p. 178). These differences are viewed in the phenomenological sense of meaning and horizon which incorporates both implicit and explicit meaning in their broadest sense. Well adjusted people have a relatively defined understanding of objects whilst psychotics have an infinite number of meanings for objects and experience. Thus, one meaning is changed to another and broadened until there is a generalisation of the initial meaning into the psychotic's whole world. Dorr-Zegers, 1988, states that "normals" have a profound difficulty in understanding this expanded horizon (Schwartz et al., 1997). Hence, the lack of understanding and inability to connect with the psychotic's world by society, the medical profession and even many mental health professionals. The only person who can provide an adequate, but not full, account of the experience and its meaning is the patient. Kaplan (1964) relates how the patient is the one intimately connected with the experience. He has a special interest in the process as it is his life so he may be able to provide some valid insight into the meaning of the experience.

The meanings that emerge in psychotic states are more "forceful, explicit and graphic" (Schwartz et al., 1997, p. 180). This expanded horizon and explicit meaning makes the psychotic's world more unmanageable and complex. When there are an overwhelming number of possibilities and interpretations for experiences available, there is a need to reduce this complexity. The psychotic will automatically select a particular, relevant meaning which is conditioned by his past beliefs and experiences. To regain control, the psychotic focuses on this meaning and behaves according to the meaning it has for him in his world. This is still not, however, shared by others and the individual remains disconnected and isolated. Schwartz et al. believe that the original, shared meaning thus recedes to the background as the psychotic reality takes precedence due to its relevance. If the psychotic does not achieve any control over his world, there is chaos and disorder, resulting in "a fragmenting of experience" (p. 181). Contrary to Jaspers (1963), however, the authors believe that these experiences can be understood by responding to the expanded horizon and its meaning for the psychotic.

There is a narrowing of experience in all psychosis when the focus is on the current meaning and experiencing and the broader perspective is lost. Eigen (1993) describes hallucinations as bringing "experience to a standstill, and one small portion of experience is heightened to an extreme degree. The subject is hypersensitive in a

highly selective way. Everything seems to gain its meaning from this small portion of experience" (p. 125). Thus, the emotional quality involved in hallucinations and delusions and the desperate need to have a sense of balance results in a lowering of the critical ability to judge. Sass (1994) describes the world of psychosis as "a place not of darkness but of relentless light, which is the natural metaphor for conscious awareness" (p. 94). This increases the intensity of the experience and narrows the field of experiencing.

The above description highlights the difference between normal and psychotic experience. Jaspers (1963) states that common reality is identifiable and accessible to all and "not merely a private and subjective matter" (p. 95). However, psychotic reality is not easily identifiable and comprehensible. Sass (1994) agrees that delusions are not always in the shared world but "rather, it is in the mind's-eye world where emotions, other people, and even the patient's own body exist as purely subjective phenomena, figments of an abstract imagination" (p. 92). The patient is always the centre of his delusion and this results in psychotic patients having severe boundary problems. They have no possibility of distancing and creating boundaries as they are "obsessed by the compactness of their being" (Corin & Lauzon, 1994, p. 44). The sense of where the self ends and the other begins is blurred and this openness to the world and experience can result in a frightening feeling of the loss of the self, or invasion and a threat of annihilation. The patient struggles to maintain a sense of mental space to allow the internal ordering of experience to occur efficiently (Eigen, 1993). Likewise, there can be a confusion in relation to body issues where a split is experienced between the self and the body. A sense of 'I' is lost or heightened and one is incapable of experiencing a common, shared reality. Thus, there are extremes of rigidity and fluctuation in symptomatology (Eigen, 1993).

Jaspers (1963) defines delusion as "a transformation in our total awareness of reality" which "can only arise in the process of thinking and judging" (p. 95). He stresses how there is no self-reflection in psychotic experience as there is in normal, everyday life. Instead there is a great deal of self-deception in the urge to escape reality. Kruger (1988) gives an account of Fischer's, 1985, views on the concept of self-deception from a phenomenological perspective. Fischer describes how the possibility of self-deception arises when three inter-related conditions are present. Firstly, the individual already has a firm belief in his understanding of a particular situation or aspect of his life. Secondly, that firm conviction may suddenly become ambiguous and uncertain due to additional information becoming available. Finally, when the ambiguity creates anxiety, not only in the person's view of the specific situation, but in the whole view of his life and world, his understanding of the phenomena will be perceived as threatening. If these conditions occur, the individual will deceive himself in order to reduce anxiety and deny the uncertainty and ambiguity. To achieve this he will realign his understanding of the experience in relation to the new information in order to maintain the status quo.

So, although the delusion provides the individual with a sense of safety, the belief is still not a reality in the eyes of the shared world and there is still some anxiety present due to avoiding the normal fears of everyday life. Sass (1994) argues that the need for a delusion may arise precisely because it is experienced as unreal rather than because

it is felt as real. He refers to Sartre's, 1966, belief that the delusion is an attempt to escape the form of life. That is, the uncertainty and the need to respond which creates anxiety, rather than its content. Fischer agrees, stating that it is easier to try and reduce anxiety than confront it. Should the person query the presence and meaning of the anxiety, he may come to the realisation that he is deceiving himself. If this is the case, the person will need to alter his current reality, attitude or understanding which may feel more anxiety-provoking. Fischer states that, if the individual listens to the anxiety he may come to recognise that the belief is fallacious. The danger of ignoring the messages received in the process of retaining the delusional belief is that the individual reaffirms that he is the person he believes himself to be or that the situation is really as he perceives it. When this occurs there is no healthy change in the belief structure to modify understanding. The experience will uncompromisingly affirm his current dysfunctional views and beliefs.

Many authors have a similar outlook on the reasons for the appearance of hallucinations. Eigen (1993) states that hallucinations may be viewed as images which could function symbolically but are taken literally. They make the abstract concrete and vice versa and recreate the meaning of reality. As stated, when the real, inner core of the self is not heard and responded to in a caring manner and healthy contact is denied, the individual seeks to provide a reality in which these basic needs can be fulfilled in some other way. So, the very lack of satisfactory interpersonal relationships forces the individual to create an alternative reality where he may control his world or be the victim, but to accept that the self is too inadequate to engage in healthy interaction is unbearable. Symbols assist us in understanding by creating an analogy which dominates reality (Jaspers, 1963). Cameron (1947) states that hallucinatory experiences, especially visual ones, often occur due to extreme feelings of personal need, anxiety or frustration and depend on the supporting delusional beliefs.

When someone experiences an hallucination there is a powerful need for that experience to be grounded in reality. Delusions are thus often associated with hallucinations in an attempt to support and make sense of that reality. Like the child who uses fantasy to conquer fears and anxieties and gain mastery over his world, delusions provide what life has denied (Noyes, 1963). Thus, delusions can be viewed as simply an exaggeration of the normal beliefs people use to bolster their perceptions of themselves and reality. When there is a large discrepancy between a person's experiencing and what appears to be the norm, the need to make the experience congruent with the personality becomes a high priority. So, the patient's reality is not necessarily a disorganisation but a "choice that has a superior claim to reality" (p. x) from the patient's perspective (Kaplan, 1964). The delusion assists in providing a meaning to the event or hallucination.

The meaning of an event is not a theoretical issue but a personal experience. Meaning changes once one addresses that particular experience and one can feel and be different. That is, there is a constant movement in awareness and perception as the meaning of the phenomenon shifts. As hallucinations are understood to be perceptions without an external stimulus, the content of the hallucination provides valuable information about the individual's perceptions and ways of interacting with the world (Noyes, 1963). Noyes views hallucinations as being projections of the individual's

psychological difficulties onto the outer world. Thus, the hallucination provides valuable clues as to what those difficulties are.

There is a "kernel of truth" (Eigen, 1993, p. 9) in psychosis. This truth allows one to recognise the common ground upon which the therapist can work with the patient to understand the value and role of the psychosis in relation to his past experiencing and how it is being acted upon in the present. To medicate away the psychosis is to obliterate the kernel of truth/reality and thus not to discover the deep roots and meaning for the individual. It becomes important to build on that kernel to heal and grow the self so that hallucinations and delusions are no longer needed. Thus, the key to the psychosis lies within the psychosis itself and how the specific meaning is linked in with the patient's world.

Prouty (1994) views hallucination as a "fragment of the self" and the "successful treatment of hallucinations is a restoration of the self" in order to restore a "communicative human self that was lost in madness or retardation" (p. xxii). Eigen (1993) describes how Jung amplified, rather than reduced, the psychosis in order to understand its meaning for the individual. By amplifying the phenomenon, the patient is allowed to leave reality for the moment to explore and play with the full meaning of the psychotic symptom. Eigen also highlights Perry's view that the psychotic's inner self is deeply wounded which results in feelings of worthlessness, inferiority and self-deprecation. He supports the need to get in touch with the core of the psychosis and self in order to truly grow.

The psychiatric labelling that so frequently occurs, results in the patient feeling "totally trapped within the psychiatric world" which is "colored by an important sense of suffering" (Corin & Lauzon, 1994, p. 23). Psychoses need not always be viewed in a negative light. Freud, Bion and Jung believe that hallucinations play a role in beginning or destroying psychic life (Eigen, 1993). Jaspers (1963) supports this belief by stating that hallucinations can be sources of human potential and possibility, not only deviations from the norm. May (1958) cautions us not to project our theories onto the patient but to ensure we are knowing him in his own reality. The thrust of questions must be about the patient's world and his experiencing. Of importance is that one does not always attempt to totally eliminate a person's defences as they may be providing a sense of stability.

Phenomenology is interested in man, not the mentally ill man, but simply man in his world. The emphasis is on meeting, hearing and understanding the unique individual and not defining him according to definitions and theory. With the growth of phenomenology and the dialogal approaches there has been a shift to understanding the patient within his context and as someone inter-relating with others in the world. Corin and Lauzon (1994) mention many authors (Giorgi, 1976, 1988, 1990; Hoeller, 1988; Messer, Sass & Woolfolk, 1988) who are challenging the objectivistic approaches. This is a healthy shift towards viewing man as a whole human being interacting and living in the world. The phenomenological viewpoint offers an alternative approach to working with psychosis other than the usual first-line treatment of neuroleptic medication.

However, these approaches to psychology are not recognised sufficiently in the psychiatric field and many schools of thought which objectify man are still prevalent in psychotherapeutic work today. Corin and Lauzon (1994) stress that the patient's individual experiences are still largely ignored. A recent study by Norcross and Freedheim (1992) affirms their position. These authors conducted a study on their predictions of the future of psychotherapy with 40 of the major contributors to a History of Psychotherapy - A Century of Change (1992). All 40 respondents held a doctorate and had an average of 27 years of postdoctoral experience. The respondents predicted that "present-centred, structured, and directive techniques would increase markedly" (p. 882). These included audio/video feedback, problem-solving techniques, cognitive restructuring, self-change techniques, behavioural contracting, social skills training and computerised therapies amongst others. This clearly indicates that the quick-fix solution mentality is firmly in place at the start of the new millennium. A warning to be heeded.

Eigen (1993) wisely comments: "Wherever madness comes from, it is with us. We must learn to live and work with it. We must find ways of letting it speak to us. We must listen to and digest its voices, visions, and enactments. We must learn to absorb and evolve with its impact" (p. 370).

As we further isolate and dehumanise people, so we increase the likelihood that they will manifest with dysfunctional behaviour in a desperate attempt to have some meaning in their chaotic, depersonalised lives.