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CHAPTER II

The existential-phenomenological foundations for the understanding of psychosis

There is a further characteristic of the current psychiatric jargon. It speaks of psychosis as a social or biological *failure* of adjustment, or *mal*-adaptation of a particularly radical kind, of *loss* of contact with reality, of *lack* of insight. As Van den Berg (1955) has said, this jargon is a veritable 'vocabulary of denigration'. The denigration is not moralistic, at least in a nineteenth-century sense; in fact, in many ways this language is the outcome of efforts to avoid thinking in terms of freedom, choice, responsibility. But it implies a certain standard way of being human to which the psychotic cannot measure up. I do not, in fact, object to all the implications in this 'vocabulary of denigration'. Indeed, I feel we should be more frank about the judgements we implicitly make when we call someone psychotic. When I certify someone insane, I am not equivocating when I write that he is of unsound mind, may be dangerous to himself and others, and requires care and attention in a mental hospital. However, at the same time, I am also aware that, in my opinion, there are other people who are regarded as sane, whose minds are as radically unsound, who may be equally or more dangerous to themselves and others, and whom society does not regard as psychotic and fit persons to be

madhouse. I am aware that the man who is said to be deluded may be in his delusion telling me the truth, and this in no equivocal or metaphorical sense, but quite literally, and that the cracked mind of the schizophrenic may *let in* light which does not enter the intact minds of many sane people whose minds are closed. Ezekiel, in Jaspers's opinion, was a schizophrenic.

I must confess here to a certain personal difficulty I have in being a psychiatrist, which lies behind a great deal of this book. This is that except in the case of chronic schizophrenics I have difficulty in actually discovering the 'signs and symptoms' of psychosis in persons I am myself interviewing. I used to think that this was some deficiency on my part, that I was not clever enough to get at hallucinations and delusions and so on. If I compared my experience with psychotics with the accounts given of psychosis in the standard textbooks, I found that the authors were not giving a description of the way these people behaved with me. Maybe they were right and I was wrong. Then I thought that maybe they were wrong. But this is just as untenable. The following seems to be a statement of fact:

The standard texts contain the descriptions of the behaviour of people in a behavioural field that includes the psychiatrist. The behaviour of the patient is to some extent a function of the behaviour of the psychiatrist in the same behavioural field. The standard psychiatric patient is a function of the standard psychiatrist, and of the standard mental hospital. The figured base, as it were, which underscores all Bleuler's great description of schizophrenics is his remark that when all is said and done they were stranger to him than the birds in his garden.

Bleuler, we know, approached his patients as a non-psychiatric clinician would approach a clinical case, with respect, courtesy, consideration, and scientific curiosity. The patient, however, is diseased in a medical sense, and it is a matter of diagnosing his condition, by observing the signs of his disease. This approach is regarded as so self-evidently justifiable by so many psychiatrists that they may find it difficult to know what I am getting at. There

are now, of course, many other schools of thought, but this is still the most extensive one in this country. It certainly is the approach that is taken for granted by non-medical people. I am speaking here all the time of psychotic patients (i.e. as most people immediately say to themselves, *not* you or me). Psychiatrists still hang on to it in practice even though they pay lip-service to incompatible views, outlook, and manner. Now, there is so much that is good and worth while in this, so much also that is *safe* in it, that anyone has a right to examine most closely any view that a clinical professional attitude of this kind may not be all that is required, or may even be misplaced in certain circumstances. The difficulty consists not simply in noticing evidence of the patient's feelings as they reveal themselves in his behaviour. The good medical clinician will allow for the fact that if his patient is anxious, his blood pressure may be somewhat higher than usual, his pulse may be rather faster than normal, and so on. The crux of the matter is that when one examines 'a heart', or even the whole man as an organism, one is not interested in the nature of one's own personal feelings about him; whatever these may be are irrelevant, discounted. One maintains a more or less standard professional outlook and manner.

That the classical clinical psychiatric attitude has not changed in principle since Kraepelin can be seen by comparing the following with the similar attitude of any recent British textbook of psychiatry (e.g. Mayer-Gross, Slater, and Roth).

Here is Kraepelin's (1905) account to a lecture-room of his students of a patient showing the signs of catatonic excitement:

> 'The patient I will show you today has almost to be carried into the room, as he walks in a straddling fashion on the outside of his feet. On coming in, he throws off his slippers, sings a hymn loudly, and then cries twice (in English), "My father, my real father!" He is eighteen years old, and a pupil of the Oberrealschule (higher-grade modern-side school), tall, and rather strongly built, but with a pale complexion, on which there is

very often a transient flush. The patient sits with his eyes shut, and pays no attention to his surroundings. He does not look up even when he is spoken to, but he answers beginning in a low voice, and gradually screaming louder and louder. When asked where he is, he says, "You want to know that too? I tell you who is being measured and is measured and shall be measured. I know all that, and could tell you, but I do not want to." When asked his name, he screams, "What is your name? What does he shut? He shuts his eyes. What does he hear? He does not understand; he understands not. How? Who? Where? When? What does he mean? When I tell him to look, he does not look properly. You there, just look! What is it? What is the matter? Attend; he attends not. I say, what is it, then? Why do you give me no answer? Are you getting impudent again? How can you be so impudent? I'm coming! I'll show you! You don't whore for me. You mustn't be smart either; you're an impudent, lousy fellow, such an impudent, lousy fellow I've never met with. Is he beginning again? You understand nothing at all, nothing at all; nothing at all does he understand. If you follow now, he won't follow, will not follow. Are you getting still more impudent? Are you getting impudent still more? How they attend, they do attend", and so on. At the end, he scolds in quite inarticulate sounds.'

Kraepelin notes here among other things the patient's 'inaccessibility':

'Although he undoubtedly understood all the questions, *he has not given us a single piece of useful information.* His talk was... *only a series of disconnected sentences having no relation whatever to the general situation*' (1905, pp. 79–80, italics my own).

Now there is no question that this patient is showing the 'signs' of catatonic excitement. The construction we put on this behaviour

will, however, depend on the relationship we establish with the patient, and we are indebted to Kraepelin's vivid description which enables the patient to come, it seems, alive to us across fifty years and through his pages as though he were before us. What does this patient seem to be doing? Surely he is carrying on a dialogue between his own parodied version of Kraepelin, and his own defiant rebelling self. 'You want to know that too? I tell you who is being measured and is measured and shall be measured. I know all that, and I could tell you, but I do not want to.' This seems to be plain enough talk. Presumably he deeply resents this form of interrogation which is being carried out before a lecture-room of students. He probably does not see what it has to do with the things that must be deeply distressing him. But these things would not be 'useful information' to Kraepelin except as further 'signs' of a 'disease'.

Kraepelin asks him his name. The patient replies by an exasperated outburst in which he is now saying what he feels is the attitude implicit in Kraepelin's approach to him: What is your name? What does he shut? He shuts his eyes.... Why do you give me no answer? Are you getting impudent again? You don't whore for me? (i.e. he feels that Kraepelin is objecting because he is not prepared to prostitue himself before the whole classroom of students), and so on . . . such an impudent, shameless, miserable, lousy fellow I've never met with . . . etc.

Now it seems clear that this patient's behaviour can be seen in at least two ways, analogous to the ways of seeing vase or face. One may see his behaviour as 'signs' of a 'disease'; one may see his behaviour as expressive of his existence. The existential-phenomenological construction is an inference about the way the other is feeling and acting. What is the boy's experience of Kraepelin? He seems to be tormented and desperate. What is he 'about' in speaking and acting in this way? He is objecting to being measured and tested. He wants to be heard.

INTERPRETATION AS A FUNCTION OF THE RELATIONSHIP WITH THE PATIENT

The clinical psychiatrist, wishing to be more 'scientific' or 'objective', may propose to confine himself to the 'objectively' observable behaviour of the patient before him. The simplest reply to this is that it is impossible. To see 'signs' of 'disease' is not to see neutrally. Nor is it neutral to see a smile as contractions of the circumoral muscles (Merleau-Ponty, 1963). We cannot help but see the person in one way or other and place our constructions or interpretations on 'his' behaviour, as soon as we are in a relationship with him. This is so, even in the negative instance where we are drawn up or baffled by an absence of reciprocity on the part of the patient, where we feel there *is no-one there* who is responding to our approaches. This is very near the heart of our problem.

The difficulties facing us here are somewhat analogous to the difficulties facing the expositor of hieroglyphics, an analogy Freud was fond of drawing; they are, if anything, greater. The theory of the interpretation or deciphering of hieroglyphics and other ancient texts has been carried further forward and made more explicit by Dilthey in the last century than the theory of the interpretation of psychotic 'hieroglyphic' speech and actions. It may help to clarify our position if we compare our problem with that of the historian as expounded by Dilthey.[1] In both cases, the essential task is one of interpretation.

Ancient documents can be subjected to a formal analysis in terms of structure and style, linguistic traits, and characteristic idiosyncrasies of syntax, etc. Clinical psychiatry attempts an analogous formal analysis of the patient's speech and behaviour.

Beyond this formal analysis, it may be possible to shed light on the text through a knowledge of the nexus of socio-historical

[1] The immediate source for the Dilthey quotations in the following passage is Bultmann's 'The problem of hermeneutics' (*Essays*, 1955, pp. 234–61).

conditions from which it arose. Similarly, we usually wish to extend as far as we can our formal and static analysis of isolated clinical 'signs' to an understanding of their place in the person's life history. This involves the introduction of dynamic-genetic hypotheses. However, historical information, *per se*, about ancient texts or about patients, will help us to understand them better only if we can bring to bear what is often called sympathy, or, more intensively, *em*pathy. When Dilthey, therefore, 'characterizes *the relationship between the author and the expositor* as the conditioning factor for the possibility of the comprehension of the text, he has, in fact, laid bare the presupposition of all interpretation which has comprehension as its basis (Bultmann, op. cit.).

'We explain', writes Dilthey, 'by means of purely intellectual processes, but we understand by means of the co-operation of all the powers of the mind in comprehension. In understanding we start from the connection of the given, living whole, in order to make the past comprehensible in terms of it.'

Now, our view of the other depends on our willingness to enlist all the powers of every aspect of ourselves in the act of comprehension. It seems also that we require to orientate ourselves to this person in such a way as to leave open to us the *possibility* of understanding him. The art of understanding those aspects of an individual's being which we can observe, as expressive of his mode of being-in-the-world, requires us to relate his actions to *his* way of experiencing the situation he is in with us. Similarly it is in terms of his present that we have to understand his past, and not exclusively the other way round. This again is true even in the negative instances when it may be apparent through his behaviour that he is denying the existence of any situation he may be in with us, for instance, when we feel ourselves treated as though we did not exist, or as existing only in terms of the patient's own wishes or anxieties. It is not a quesion here of affixing predetermined meanings to this behaviour in a rigid way. If we look at his actions as 'signs' of a 'disease', we are already imposing our categories of thought on to the patient, in

a manner analogous to the way we may regard him as treating us; and we shall be doing the same if we imagine that we can 'explain' his present as a mechanical resultant of an immutable 'past'.

If one is adopting such an attitude towards a patient, it is hardly possible at the same time to understand what he may be trying to communicate to us. To consider again the instance of listening to someone speaking, if I am sitting opposite you and speaking to you, you may be trying (i) to assess any abnormalities in my speech, or (ii) to explain what I am saying in terms of how you are imagining my brain cells to be metabolizing oxygen, or (iii) to discover why, in terms of past history and socio-economic background, I should be saying these things at this time. Not one of the answers that you may or may not be able to supply to these questions will in itself supply you with a simple understanding of what I am getting at.

It is just possible to have a thorough knowledge of what has been discovered about the hereditary or familial incidence of manic-depressive psychosis or schizophrenia, to have a facility in recognizing schizoid 'ego distortion' and schizophrenic ego defects, plus the various 'disorders' of thought, memory, perceptions, etc., to know, in fact, just about everything that can be known about the psychopathology of schizophrenia or of schizophrenia as a disease without being able to understand one single schizophrenic. Such data are all ways of *not* understanding him. To look and to listen to a patient and to see 'signs' of schizophrenia (as a 'disease') and to look and to listen to him simply as a human being are to see and to hear in as radically different ways as when one sees, first the vase, then the faces in the ambiguous picture.

Of course, as Dilthey says, the expositor of a text has a right to presume that despite the passage of time, and the wide divergence of world view between him and the ancient author, he stands in a not entirely different context of living experience from the original writer. He exists, in the world, like the other, as a permanent object in time and place, with others like himself. *It is just this presupposition that one cannot make with the psychotic.* In

this respect, there is thus a greater difficulty in understanding the psychotic in whose presence we are here and now, than there is in understanding the writer of a hieroglyphic dead for thousands of years. Yet the distinction is not an essential one. The psychotic, after all, as Harry Stack Sullivan has said, is more than anything else 'simply human'. The personalities of doctor and psychotic, no less than the personalities of expositor and author, do not stand opposed to each other as two external facts that do not meet and cannot be compared. Like the expositor, the therapist must have the plasticity to transpose himself into another strange and even alien view of the world. In this act, he draws on his own psychotic possibilities, without forgoing his sanity. Only thus can he arrive at an understanding of the patient's *existential position.*

I think it is clear that by 'understanding' I do not mean a purely intellectual process. For understanding one might say love. But no word has been more prostituted. What is necessary, though not enough, is a capacity to know how the patient is experiencing himself and the world, including oneself. If one cannot understand him, one is hardly in a position to begin to 'love' him in any effective way. We are commanded to love our neighbour. One cannot, however, love this particular neighbour for himself without knowing who he is. One can only love his abstract humanity. One cannot love a conglomeration of 'signs of schizophrenia'. No one *has* schizophrenia, like having a cold. The patient has not 'got' schizophrenia. He is schizophrenic. The schizophrenic has to be known without being destroyed. He will have to discover that this is possible. The therapist's hate as well as his love is, therefore, in the highest degree relevant. What the schizophrenic is to us determines very considerably what we are to him, and hence his actions. Many of the textbook 'signs' of schizophrenia vary from hospital to hospital and seem largely a function of nursing. Some psychiatrists observe certain schizophrenic 'signs' much less than others.[1]

[1] There is now an extensive literature to support this view. See, for example, 'In the Mental Hospital' (articles from *The Lancet*, 1955–6).

I think, therefore, that the following statement by Frieda Fromm-Reichmann is indeed true, however disturbing it is: '. . . psychiatrists can take it for granted now that in principle a workable doctor-patient relationship can be established with the schizophrenic patient. If and when this seems impossible, it is due to the doctor's personality difficulties, not to the patient's psychopathology' (1952, p. 91).

Of course, as with Kraepelin's catatonic young man, the individual reacts and feels towards oneself only partially in terms of the person one takes oneself to be and partially in terms of his phantasy of what one is. One tries to make the patient see that his way of acting towards oneself implies a phantasy of one kind or another, which, most likely, he does not fully recognize (of which he is unconscious), but which, nevertheless, is a necessary postulate if one is to make any sense of this way of conducting himself.

When two sane persons are together one expects that *A* will recognize *B* to be more or less the person *B* takes himself to be, and vice versa. That is, for my part, I expect that my own definition of myself should, by and large, be endorsed by the other person, assuming that I am not deliberately impersonating someone else, being hypocritical, lying, and so on.[1] Within the context of mutual sanity there is, however, quite a wide margin for conflict, error, misconception, in short, for a disjunction of one kind or another between the person one is in one's own eyes (one's being-for-oneself) and the person one is in the eyes of the other (one's being-for-the-other), and, conversely, between who or what he is for me and who or what he is for himself; finally, between what one imagines to be his picture of oneself and his attitude and intentions towards oneself, and the picture, attitude, and intentions he has in actuality towards oneself, and vice versa.

That is to say, when two sane persons meet, there is a mutual and reciprocal recognition of each other's identity. In this mutual recognition there are the following basic elements:

[1] There is the story of the patient in a lie-detector who was asked if he was Napoleon. He replied, 'No'. The lie-detector recorded that he was lying.

(a) I recognize the other to be the person he takes himself to be.
(b) He recognizes me to be the person I take myself to be.

Each has his own autonomous sense of identity and his own definition of who and what he is. You are expected to be able to recognize me. That is, I am accustomed to expect that the person you take me to be, and the identity that I reckon myself to have, will coincide by and large: let us say simply 'by and large', since there is obviously room for considerable discrepancies.

However, if there are discrepancies of a sufficiently radical kind remaining after attempts to align them have failed, there is no alternative but that one of us must be insane. I have no difficulty in regarding another person as psychotic, if for instance:

he says he is Napoleon, whereas I say he is not;

or if he says I am Napoleon, whereas I say I am not;

or if he thinks that I wish to seduce him, whereas I think that I have given him no grounds in actuality for supposing that such is my intention;

or if he thinks that I am afraid he will murder me, whereas I am not afraid of this, and have given him no reason to think that I am.

I suggest, therefore, that *sanity or psychosis is tested by the degree of conjunction or disjunction between two persons where the one is sane by common consent.*

The critical test of whether or not a patient is psychotic is a lack of congruity, an incongruity, a clash, between him and me. The 'psychotic' is the name we have for the other person in a disjunctive relationship of a particular kind. It is only because of this interpersonal disjunction that we start to examine his urine, and look for anomalies in the graphs of the electrical activity of his brain.

It is worth while at this point to probe a little further into what

is the nature of the barrier or disjunction between the sane and the psychotic.

If, for instance, a man tells us he is 'an unreal man', and if he is not lying, or joking, or equivocating in some subtle way, there is no doubt that he will be regarded as deluded. But, existentially, what does this delusion mean? Indeed, he is not joking or pretending. On the contrary, he goes on to say that he has been pretending for years to have been a real person but can maintain the deception no longer.

His whole life has been torn between his desire to reveal himself and his desire to conceal himself. We all share this problem with him and we have all arrived at a more or less satisfactory solution. We have our secrets and our needs to confess. We may remember how, in childhood, adults at first were able to look right through us, and into us, and what an accomplishment it was when we, in fear and trembling, could tell our first lie, and make, for ourselves, the discovery that we are irredeemably alone in certain respects, and know that within the territory of ourselves there can be only our footprints. There are some people, however, who never fully real-ize themselves in this position. This genuine privacy is the basis of genuine relationship; but the person whom we call 'schizoid' feels both more exposed, more vulnerable to others than we do, and more isolated. Thus a schizophrenic may say that he is made of glass, of such transparency and fragility that a look directed at him splinters him to bits and penetrates straight through him. We may suppose that precisely as such he experiences himself.

We shall suggest that it was on the basis of this exquisite vulnerability that the unreal man became so adept at self-concealment. He learnt to cry when he was amused, and to smile when he was sad. He frowned his approval, and applauded his displeasure. 'All that you can see is not me,' he says to himself. But only in and through all that we do see can he be anyone (in reality). If these actions are not his real self, he is irreal; wholly symbolical and equivocal; a purely virtual, potential, imaginary person, a

'mythical' man; nothing 'really'. If, then, he once stops pretending to be what he is not, and steps out as the person he has come to be, he emerges as Christ, or as a ghost, but not as a man: by existing with no body, he is no-body.

A 'truth' about his 'existential position' is lived out. What is existentially' true is lived as 'really' true.

Undoubtedly, most people take to be 'really' true only what has to do with grammar and the natural world. A man says he is dead but he *is* alive. But his 'truth' is that he is dead. He expresses it perhaps in the only way common (i.e. the communal) sense allows him. He means that he is 'really' and quite 'literally' dead, not merely symbolically or 'in a sense' or 'as it were', and is seriously bent on communicating his truth. The price, however, to be paid for transvaluating the communal truth in this manner is to 'be' dead, for the only *real* death *we* recognize is biological death.

The schizophrenic is desperate, is simply without hope. I have known a schizophrenic who could say he was loved, as a child by God the Father or by the Mother of God or by another person, either *is* God, or the Devil, or in hell, estranged from God. When someone says he is an unreal man or that he is dead, with deep seriousness, expressing in radical terms the stark truth of his existence as he experiences it, that is – insanity.

What is required of us? Understand him? The kernel of the schizophrenic's experience of himself must remain incomprehensible to us. As long as we are sane and he is insane, it will remain so. But comprehension as an effort to reach and grasp him, while remaining within our own world and judging him by our own categories whereby he inevitably falls short, is not what the schizophrenic either wants or requires. We have to recognize all the time his distinctiveness and differentness, his separateness and loneliness and despair.[1]

[1] Schizophrenia cannot be understood without understanding despair. See especially Kierkegaard, *The sickness unto death* (1954); Binswanger, 'The Case of Ellen West' (1958); Leslie Farber, 'The therapeutic despair' (1958).