Models of Psychosis and the Limitations of Psychiatric Knowledge

Practice-Based Research Paper

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Author Note

In this paper I have at times used "they" as a singular pronoun. This is in an effort to include individuals who do not identify as "he/him" or "she/her" but who exist elsewhere on the gender spectrum.

Abstract

In this paper, the medical discourse on the constructs of "psychosis" and "schizophrenia" is challenged by a literature review of contradictory evidence, alternative theories, phenomenological explorations of psychosis, and perspectives of people who have experienced psychosis. One purpose is to expose the violence that occurs in constructing madness as an illness and "treating" it through pharmacology, while another is to deconstruct the binary of "sane" versus "insane" by examining the social and existential factors that may contribute to the development of psychosis. Implications for social work practice are discussed.

Chapter One: Introduction

This paper examines the nature of madness and describes the ways psychosis is framed through various perspectives, including psychiatry, psychology, philosophy, and among those who experience it. I chose to write this paper because I believe that people with psychosis are among the most vilified, misunderstood, and feared people in society. Through a review of the literature I intend to articulate the inadequacies in the dominant psychiatric model, and to bring forward alternative opinions on psychosis, including qualitative descriptions from those who experience the phenomenon. I also will argue that even if psychiatric and biological theories are found to be scientifically correct, they may be inadequate for improving the lives of many people since these theories do not make room for personal agency or meaning in the psychotic experience, and thereby are silencing, disempowering, and violent to individuals.

According to medical definitions, *psychosis*, a psychological state that is framed as a departure from 'reality' in the form of hallucinations and delusions, is found in conditions such as schizophrenia, schizoaffective disorder, and mania. In Western psychiatry and much of public discourse, mental health conditions involving psychosis are framed as 'illnesses' or 'diseases' of the brain, and the public has been informed that individuals with these diseases, especially schizophrenia, must be 'treated' long-term with medication. Discourse is beginning to change, with mental health organizations acknowledging that psychotic disorders can have a varying course, with many people returning to their "previous level of functioning" (Schizophrenia Society of Ontario, 2013), especially with "medication and psychosocial interventions" (Centre for Addiction and Mental Health, 2012). Nonetheless, psychosis is predominantly considered a phenomenon of certain 'sick' individuals who are considered to be afflicted with a worldview

that differs from reality, specifically with not being able to "tell the difference between what is

real and what is imagined" (Centre for Addiction and Mental Health, 2012).

However, psychiatric definitions and explanations are highly contested, both by theorists

who engage in long-term therapy with people who experience psychosis, and by the people who

experience psychosis. Many researchers and people in the medical profession interpret

psychosis as entirely a biological disease caused by differences in brain structure. They note that

psychosis suppresses the parts of the brain that would give people "insight" into realizing that

they are sick. However, many people who have experienced psychosis are convinced that

psychiatry is a form of social control, designed to suppress dissenting voices by labelling them as

"ill". In the middle are those who believe that psychosis is caused by a combination of

environmental and biological factors, and that both psychosis and social discrimination can lead

to distress or suffering but, overall, people should not receive psychiatric treatment unless they

want this or if they may harm themselves or others. From my literature review, I found that there

are conflicting studies regarding whether schizophrenia is indeed a "brain disease". The areas of

research with the most conflicting results are studies of whether structural brain changes occur

before or after the onset of psychosis symptoms, or before or after patients start taking

psychiatric medication. I do not have the expertise to examine these contradictory studies to

determine if either has methodological flaws. Another area of study for which I have seen mixed

results is whether people who take psychiatric medication have a more or less "chronic course"

of psychotic episodes. In other words, do psychiatric medications worsen or improve the long-

term symptoms of psychosis? My purpose in this paper, however, is to show that framing

psychosis and schizophrenia as "brain diseases" amounts to violence because people who

experience these conditions, who often derive deep personal significance from them, are then dismissed as unreliable narrators of their own experience.

I will argue that psychosis is based on the social world, not just on the isolated individual's biology. Qualitative and quantitative studies (reviewed in Bentall, 2003, pp. 477-483) provide evidence that the role of severe anxiety and trauma on the development of psychosis has been underplayed by psychiatry, as has the likelihood of recovery (Williams, 2012, pp. 39-41). The content of psychotic hallucinations vary depending on predominant themes in the culture (Luhrmann, 2013; Bentall, 2003), and philosophical and psychological theories on the development of the self in the social world can offer explanations for psychosis that tend to be consistent with self-reports of people who have experienced psychosis (e.g., Williams, 2012; Harrop & Trower, 2003). This paper will report on evidence that madness is dependent on the culture's or community's interpretation of reality. These theories of psychosis may have significant value in destigmatizing and normalizing psychotic experiences. Descriptions of psychosis as it appears to medical professionals overlook the phenomenological experience of psychosis, assuming that the behaviour of individuals with psychosis has no rationale and that individuals with psychosis lack the insight to make sense of their own experiences. The research on the actual experience of psychosis is scant, and even the definition of schizophrenia is highly contested and lacking in validity (Geekie & Read, 2009). Constructs such as schizophrenia, psychosis and madness rely on the presupposition that there is an objective reality and that, once individuals cross a threshold of departure from this construct of reality, they become insane.

My research question is: In what ways can studying subjective experiences and alternative theories of psychosis reduce suffering, challenge current psychiatric knowledge, and deconstruct the binary of "sanity" and "insanity"?

Some people who experience conditions that make them unable to work in a capitalist system may be framed as "psychotic" and are dehumanized. The "recovery model" (which holds that remission of symptoms of psychosis and return of some or all functional capacities for living in society are possible) is gaining popularity and evidence, and it is finding support in mainstream agencies, but I am concerned that it will be co-opted because it proposes that individuals with psychosis can be reintegrated into a neoliberal economy. Although many people experiencing psychosis cannot work in the job market, I will argue that these people's worldviews, which challenge dominant reality, may be considered threatening. The systemic suppression of "psychotic" worldviews invalidates the belief, in certain individuals and cultures, that psychosis can be a spiritual journey or a process of renewal and growth; or that psychosis is a spiritual crisis that involves deconstructing and then reconstructing reality in a more adaptive way for the individual, and this process is often interrupted by the psychiatric system (Williams, 2012). People who are interpreted as experiencing madness have been subjected to domination and control in modern Western societies. I hope to collect possible reasons as to why this is the case—what is it about the worldviews of people with psychosis that requires its suppression?

This paper will describe some of the evidence for and against psychiatric interpretations of psychosis, as well as other explanations that have been proposed for psychosis. These findings may help problematize the unethical and troubling practice of insisting on the medicalization of people who may not feel that they are ill. This corresponds with critical social work by bringing oppressed and marginalized voices to the forefront.

Psychosis relates to social work inasmuch as social workers deal with people who experience the condition, as their case managers, counsellors, and enforcers but also because social work as a profession claims to advocate for social justice and to challenge oppression.

Nonetheless, social workers often act as agents of the state, and therefore state control, instead. Social workers work in organizations that are increasingly restricted by medicalized models of human emotional suffering and by "evidence-based" methods of treatment. Few social workers are equipped to work with people experiencing psychotic episodes, since these conditions are framed as requiring medical intervention and the people experiencing psychosis are framed as irrational, nonsensical, unpredictable, and possibly dangerous, unless they stick to a medication regime. The increased risk for certain oppressed or marginalized peoples, such as immigrants and people of lower socioeconomic status, of being diagnosed with schizophrenia, is of extreme relevance to critical social workers because there is evidence that social injustice may be a factor both in the development of psychosis as well as its diagnosis. This is further incentive for social workers to fight systems of oppression. Challenging the binary of mentally ill versus mentally healthy could be anti-oppressive and highly relevant to social workers.

I am located as a critical social worker-in training who has an undergraduate degree in psychology. My stake in this research is my own experience with mental health concerns. I have had psychological experiences that I believe could have been classified as *prodromal* or pre-psychotic symptoms. These experiences involved doubt and deconstruction of societally accepted constructs of reality, combined with feelings of groundlessness, depersonalization, and social isolation. Later, curiously, I experienced these same feelings while learning about poststructuralist influences on social work. I believe that this could have progressed to psychosis were I not lucky enough to have supportive relationships and been privileged with social mobility. Although I can accept that there could have been chemical, biological reasons for these feelings, this does not exclude the presence of relevant social contexts that could have influenced my unusual and troubling perceptions of concepts that many people take for granted.

I never took antipsychotic medication so I do not know if it would have helped. Although I do

not doubt that psychiatric drugs can produce considerable relief and help some people feel

"normal" or "stable," I will later describe research on psychiatric drugs that suggest that using

them as the primary method of "treating" psychosis is unethical.

I was raised in Canada and have been shaped by the prevailing notions of sanity, insanity,

and psychology. I am writing to an audience that has a general idea of the way "madness" is

defined and viewed in Western medicine and in the North American dominant culture, although

many have gross misconceptions, including that people with psychosis are inherently dangerous

or violent, that they are always experiencing psychosis, or that they are doomed to worsening

lifelong illness. I have read that people who display aspects of what is now called "psychosis,"

such as voice-hearing, have been venerated as shamans, condemned as possessed by demonic

forces, and praised as religious or philosophical leaders throughout history and prehistory, but

this is not the focus of my research since most published studies on other cultures' ways of

interpreting psychosis come from a Western medical perspective and focus on the

"psychoeducation" of other cultures. Furthermore, colonization has led to many communities

adopting a Western conception of mental illness, whether or not these communities defined

certain people as mad prior to colonization. However, a preliminary look at the research finds

that psychosis is also frequently viewed as a negative experience outside of Western medical

contexts, albeit with different causes. For example, a study (Shibre, Teferra, Morgan & Alem,

2010) on people living the "semi-nomadic" Borana community of Ethiopia found that, although

previous studies been found to have no people with psychosis in the community, the people had

a word for the construct of madness, and with the researchers' guidance, were able to "identify"

members of their community who were diagnosed with severe mental illness. Teferra and Shibre

(2012) interviewed this community again about their perceived causes and treatments of madness, and found a variety of responses: bewitchment, evil spirit attack (particularly in the case of what could be diagnosed as postpartum psychosis), "exposure to blood, war and dirty water," "thinking too much," alcohol and khat use, malaria infection, and heritability; Western psychiatrists would agree with some of these but certainly not others. Borana interviewees generally preferred for madness to be treated by wise men or healers, exorcism, prayer, or holy water, rather than Western medicine. Many interviewees noted that their traditional treatments successfully treated the psychosis. Consequently, even in cultures that view psychosis as a negative or irrational experience, there is variation in belief about cause and effective treatment.

Theoretical Framework

Among psychiatrists, survivors of psychosis, and other theorists working with individuals with psychosis, there are countless opinions of the definitions, experience, and causes of psychosis and schizophrenia. This paper will argue that the internal experiences and subjective viewpoints of those who experience psychosis must be honoured in order to avoid psychiatric violence. I will approach this topic from the perspective that psychosis is not simply a mental illness located within a person, but that it is constructed as a mental illness due to its apparent incompatibility with socially determined assumptions of normality. This paper will use the theories of social constructivist epistemology to argue that our knowledge of psychosis is shaped through social discourse. For my work, I am influenced by poststructuralist beliefs that reality is socially constructed; hence an individual experiencing psychosis is failing to conform to social norms, as opposed to some "truth" about reality. Therefore, labelling their experiences as "illness" amounts to privileging certain realities over other suppressed realities, which is

structural violence. This paper incorporate phenomenological accounts and existential and philosophical perspectives on psychosis.

I will also argue that, although the experience of psychosis—inasmuch as it is a discrete and definable condition—frequently entails tremendous suffering and isolation, this is not only due to the phenomenon of psychosis but also to the way it manifests in reaction to the society (as described in Luhrmann, 2013) and due to discrimination, and overgeneralized fear associated with the phenomenon. Psychosis is more harmful and limiting to the individual than it needs to be, I propose, because it is invalidated, feared, and brutally discriminated against in many societies, which in turn heightens beliefs of persecution, isolation, or hopelessness to the individual. Therefore, psychosis is dynamic and responsive. Psychosis may be frightening or isolating to the individual, but it may be more harmful for them to be given a label that leads to discrimination, such as chronically mentally ill or disabled. Studies (Read & Haslam, 2004) have found that pressing the "mental illness" model of psychosis actually increases public prejudice against psychosis, in part because it frames people with psychosis as sick, and therefore different and malfunctioning.

Certain research has influenced me to believe that psychosis should not automatically be considered as dangerous or pathological. In fact, this paper will review theories that view psychosis as a mechanism of spiritual growth, or resistance to dehumanizing aspects of society. This paper will review evidence that psychosis is a byproduct of human consciousness, experience, and social interaction, and as a result any professional who is meant to "help" or "support" others must be aware of ways in which they are actually silencing or suppressing other realities. Furthermore, there is evidence that psychosis has positive meaning and significance for some people who experience it, especially those who recover—and many do recover, with or

without antipsychotic medication (Williams, 2012; Chadwick, 2009). A vocal proportion of people with "mental illness" view themselves as blessed with transformative insight and not needing treatment. As such, labelling these potentially adaptive experiences as purely detrimental, delusional, or meaningless is oppressive. People who are seen as experiencing psychosis, whether they agree with this explanation or not, have been denied agency and the platform to define their own experiences; hence they have been subject to extreme violence in the form of psychiatric "treatments" and imprisonment (both in psychiatric asylums and in the criminal justice system—see Torrey et al., 1992).

Individuals who do feel that they are suffering in emotional and cognitive isolation due to psychosis should be given access to validation, support, and friendship without coercive treatment, and be afforded agency in determining treatment. I do not doubt that there is a biological component to psychosis as there is to any other aspect of the mind, but I believe that actually treating psychosis as a medical condition that requires suppression, given the existential nature of psychotic experience, amounts to medically sanctioned violence. Space need to be opened up for different ways of perceiving and knowing, and if an individual truly wants support to reintegrate into society, this should be directed by the individual. Reintegrating should be done not only by helping the individual adapt to society but by incorporating their insights into the society.

Chapter Two: Research Design

This paper consists of a review and analysis of the available literature. It is a critical review of the literature and discourse surrounding psychosis and "madness." The literature review will include accounts on the phenomenological experiences of psychosis and a review of theories on what psychosis actually means for individuals, as well as other theories of psychosis

outside of the medical model. This paper will also review the ways that madness has been

constructed historically and in modernity, with attempts to be inclusive of many cultural

interpretations. I chose not to do interviews for ethical reasons, and also because I have limited

experience with people who have experienced psychosis. Given the discrimination and

marginalization these people experience, I could only ethically interview them if I had time for

follow up interviews to debrief them, or if they received immediate benefits from the interview.

Furthermore, my paper is meant to counter medical perspectives on schizophrenia, which could

be threatening for many agencies I could recruit from, outside of "recovery"-focused agencies.

For these reasons, I chose instead to review the literature for interviews that have already been

done in other studies. First, I read peer-reviewed journal articles on psychosis and schizophrenia

data. Through a review of these journal articles, I gathered substantial information about

psychosis and the ways in which it is and has been framed. I searched databases like PsycINFO

and EBSCOhost for terms such as "experience of psychosis," "phenomenology of psychosis,"

"theories of psychosis," "philosophy of psychosis," and "first person accounts of psychosis,"

interchanging "psychosis" with "schizophrenia." *Schizophrenia Bulletin* and *Psychosis:

Psychological, Social and Integrative Approaches* are two journals that were highly informative.

As well as peer reviewed journal articles, I used books written by people who have

experienced psychosis and/or have worked with people with psychosis, especially books that

explore philosophies of psychosis and the phenomenological experience of psychosis. I also

referred to online forums, which provided insight into the ways that people with psychosis view

their illness, or if they even view it as an illness at all; Mad Activism groups and many

individuals with schizophrenia tend to view psychosis as a different, valid, and partly intentional

way of being in the world instead of simply a series of symptoms (Geekie & Read, 2009). I will

describe how these people resist the dominant discourse of sanity. I will incorporate Foucault (1964), who examines the ways in which madness has been constructed and the systems in power that framed certain people as "mad" throughout history and modernity. In a portion of the discussion, I will use a poststructuralist paradigm to examine constructs like "psychosis," "schizophrenia," and "madness," the ways they have been framed historically, and the ways in which they are used to oppress certain people and invalidate their realities. I will also examine the discourse on psychosis and schizophrenia from information published by medical providers, particularly on their websites.

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Chapter Three: Literature Review and Analysis

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Psychosis and Schizophrenia: Definitions

This paper will focus on *psychosis*, but in my review of the literature I also reviewed literature on *schizophrenia*, a "mental illness" that is characterized by frequent, chronic episodes of psychosis. Both *psychosis* and *schizophrenia* are terms that are used in medical literature to describe a condition that the layperson might call *craziness*, *madness,* or *insanity.* Although the terms are not strictly interchangeable, for my literature review I reviewed articles and books that discussed "schizophrenia," "psychosis" or "madness." I combined literature on these three different terms because all of them describe behaviour or beliefs that are seen as abnormal, although "schizophrenia" is a diagnosis of a chronic condition and the other two terms do not necessarily imply this. The symptoms of schizophrenia are not particularly well distinguished from psychosis. Psychosis is not a distinct diagnosis in the American Psychological Association's (APA) *Diagnostic and Statistics Manual, Fifth Edition* (DSM-V) (2013), but it is a component of diagnoses such as schizophrenia, bipolar disorder, and depressive disorder with psychotic features.

Many peer-reviewed journal articles assume consistent definitions for terms like "schizophrenia" and "psychosis" and therefore do not define these terms at all. However, a review of the literature finds that these terms lack consistency, and that they are highly variable in described symptoms, course, proposed cause and outcome, as will be discussed. Furthermore, the terms are presented to the public in a vague and inconsistent manner. When I, in my home province of Ontario, Canada, performed a Google search for "psychosis" or "schizophrenia," the first websites to appear are ones that give psychiatric, medical definitions of these conditions. This should hardly be surprising since both are medical terms. However, stating the definitions for these terms as fact fails to acknowledge the contentious debates about whether "mental illnesses" are illnesses like any other, and whether they should be treated that way.

From my Google search, *psychosis* is defined as "a serious but treatable medical condition that reflects a disturbance in brain functioning" (Canadian Mental Health Association, 2013), "a loss of contact with reality" that is "frightening, confusing and distressing" (Centre for Addiction and Mental Health, 2012), "a condition that affects a person's ability to know what is real versus what is not real" (Ehmann et al., 2012, p. 7), and "conditions that affect the mind, in which there has been some loss of contact with reality" (Fraser Health Authority, 2013). *Schizophrenia* was defined in 2000 by the American Psychological Association as psychotic symptoms persisting for at least six months, combined with an impairment in functioning (Martens, 2007). In the Google search, *schizophrenia* is presented to the public as a "serious mental illness" (Schizophrenia Society of Canada, 2014), a "chronic and serious disease of the brain" (Schizophrenia Society of Ontario, 2013), and "a chronic, severe, and disabling brain disease" (Schizophrenia.com, 2002). The emphasis is on the concept of a "chronic," "serious" or "severe" "mental illness" or "disease" of the "brain," although the Fraser Health Authority did

use a more mysterious term: "mind." The Canadian Mental Health Association (2013) states that

schizophrenia is "a mystery, a puzzle with missing pieces" (2013) involving "disturbed

thinking." The website also elaborates: "This complex biochemical brain disorder affects a

person's ability to determine what is reality and what is not. It is as though the brain sends

perceptions along the wrong path, leading to the wrong conclusion." The Canadian Mental

Health Association (2013) is the only website of these first Google options to acknowledge in its

definition the complexity and mystery of defining the term.

Larger organizations have definitions for schizophrenia that are equally broad: a

publication by Nations for Mental Health (1998), a subdivision of the World Health

Organization, defined it as "major mental disorder, or group of disorders, whose causes are still

largely unknown and which involves a complex set of disturbances of thinking, perception,

affect and social behaviour" and, on the World Health Organization website it was defined as:

> a severe mental disorder, characterized by profound disruptions in thinking, affecting
>
> language, perception, and the sense of self. It often includes psychotic experiences, such
>
> as hearing voices or delusions. It can impair functioning through the loss of an acquired
>
> capability to earn a livelihood, or the disruption of studies (World Health Organization,
>
> 2014).

> On the other hand, the National Institute for Mental Health defines schizophrenia as:

> a chronic, severe, and disabling brain disorder … people with the disorder may hear
>
> voices other people don't hear… They may believe other people are reading their
>
> minds… This can terrify people with the illness and make them withdrawn or extremely
>
> agitated. People with schizophrenia may not make sense when they talk… Sometimes

people with schizophrenia seem perfectly fine until they talk about what they are really

thinking (National Institute for Mental Health, n.d.).

Thus schizophrenia is defined by its variability. Overall, however, the medical

definitions focus on the idea of it being a disabling illness that is characterized by disrupted

thoughts and behaviour. Overall, 45 million people in the world are estimated to "have

schizophrenia," men are diagnosed younger than women, and 50% to 80% of people develop

schizophrenia in late adolescence or early adulthood (Harrop & Trower, 2003).

Psychosis is defined in different ways according to what is believed to be its underlying

mechanism. In Western medicine, as mentioned, it is a condition of severe impairment in reality

testing, often with the presence of hallucinations, delusions, bizarre behaviour, impairments in

cognition and understandable speech, and distorted self-perception. Many of these components

require definitions of their own, as well as assumptions of what qualifies as normal behaviour

and non-distorted thought. The definition for *delusion* as well as *bizarre delusion,* for example,

has undergone multiple DSM revisions. Just a sample of other definitions of psychosis include:

"an altered state of existence dominated by idolisation, ethical escapism, and terrifying and

enthralling transcendence" (Morrison, 2007, p. 561), "losing contact with oneself" (Mould,

Oades, & Crowe, 2010, p. 282); and an expression of existential angst (Keller, 2008). The

moment when a person enters psychosis is framed as a "psychotic break" (from reality, it is

implied) or sometimes a "nervous breakdown." The variance in definitions makes psychosis

appear merely to encompass thoughts and behaviours that are considered to be confusing,

troubling, counterintuitive, or repellent to the dominant group.

A substantial number of studies argue that the construct of schizophrenia is not

scientifically reliable. Read (2004b) notes that, according to the DSM-IV, released by the APA

in 1994, "There are 15 ways… in which two people can meet DSM-IV's criteria for schizophrenia without having anything in common" (p. 46)—that is, without sharing any of the DSM-IV required "two of five 'characteristic symptoms' – hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms" (p. 46). Furthermore, although we can surmise that someone is experiencing a "hallucination" if they hear a voice that no one else can hear, it is much more difficult and subjective to determine if someone is experiencing a "delusion" or "disorganized speech"—this assumes that we know some objective truth about reality and that there is only one acceptable way to communicate. Read (2004b) also reviews studies that demonstrate troubling low concurrence among clinicians in diagnosing schizophrenia, and others showing that, given the same set of symptoms, many more American clinicians than British clinicians (69% versus 2%) would diagnose schizophrenia. These studies suggest that there is little agreement over who has schizophrenia. Read (2004b) reviewed the literature and found that schizophrenia, even if it were reliably diagnosed, lacks predictive validity due to inconsistencies in symptoms and prognosis. Read (2004b) argues that some subcategories of schizophrenia may have reliability, but overall research on schizophrenia as a whole is bound to fail due to the construct being invalid and unreliable. Nonetheless, research continues to be done on people diagnosed with schizophrenia despite the heterogeneity of symptoms and outcomes. Thus when this paper presents research on schizophrenia, it is important to remember that the diagnosis, and therefore much of the research, has questionable validity.

Among many psychiatrists, *schizophrenia* is a term that is falling out of favour due to its heterogeneous symptoms and due to inconsistencies in definition, diagnosis, treatment, and outcome (Aviv, 2010; McGuire, 2000). Its symptoms and outcomes are so diverse and

unpredictable that it appears to be many conditions melded together. Bentall (1990) is commonly

cited as stating that schizophrenia is a disease with "no particular symptoms, no particular

course, no particular outcome and which responds to no particular treatment" (p. 33).

Psychiatric Explanations and Treatment

The first individuals in Western medicine to attempt to define and categorize

schizophrenia were Emil Kraepelin and Eugen Bleuler. Emil Kraepelin is widely acknowledged

as the first person to describe schizophrenia, although he called it *dementia praecox* and viewed

it as a chronic, degenerative form of dementia. This early description has convinced

psychiatrists and the public alike that most people cannot "recover" from schizophrenia but that

its symptoms can be managed, if only people stick to their treatment regimens. There is

evidence that Kraepelin was combining people with many different syndromes into the dementia

praecox label, including those with organic brain deterioration caused by other factors (Read,

2004c).

Eugen Bleuler coined the term "schizophrenia," translating into "split mind" (which will

forever confuse the lay public into thinking that schizophrenia involves experiencing multiple

personalities—it is not typically thought to be the same as "split personalities" or *dissociative*

identity disorder, which is not the topic of this paper). Schizophrenia was "treated" throughout

the 20th century by deliberately bringing about damage to the brain, either through insulin-

induced comas, electroshock therapies, or lobotomies, all of which led to significant

deterioration in cognition (Bentall, 2009). In the 1950s, certain drugs, originally called

neuroleptics and later dubbed *antipsychotics*, were found to reduce (although not often

eliminate) psychotic symptoms, often while causing serious sedation and side effects. When it

was found that these drugs blocked the activity of a neurotransmitter, dopamine, in the brain

(usually by blocking dopamine receptors, preventing the dopamine from sending messages), it was postulated that schizophrenia and psychosis were caused by excessive dopamine. This is despite the fact that this has never been successfully demonstrated in scientific studies (Read, 2004a). The major side effects of antipsychotic drugs are "*Parkinsonianism* (stiffness and tremor), *dystonias* (involuntary muscle movements), *akathisia* (an extremely distressing kind of restlessness, leading to obvious fidgeting) and tardive dyskinesia (involuntary movements, usually of the jaw and tongue)" (Bentall, 2009, p. 223). These side effects occur even while some psychotic symptoms remain present, indicating that there is no direct line from too much dopamine (causing psychosis) to just the right amount, to too little (causing side effects).

Although many psychiatrists, case workers, and members of the public maintain Kraepelin's belief that schizophrenia is chronic and degenerative, multiple long-term studies have shown that a significant proportion of people eventually "recover," or cease to experience most or all symptoms of schizophrenia, not just due to psychiatric medication but especially due to integration and skill training in communities (Read, 2004c). The American Psychological Association (APA) even has an article on its website that notes that many psychiatrists are skeptical of recovery, but this is primarily due to their failing to keep up to date on recovery research, and also because they employ a circular logic that states that anyone who recovers from schizophrenia was misdiagnosed in the first place (McGuire, 2000). This circular logic was first employed by Kraepelin, who was certain that he had named a degenerative disease and that those who improved had been misdiagnosed (Read, 2004c).

Causes attributed to schizophrenia and psychosis are diverse. Psychiatric and medical models assume that underlying, genetic biological abnormalities may be intensified by stress and can lead to psychosis. A member of the public who searches Google for causes of schizophrenia

would find no consensus answer. According to Schizophrenia.com (2010) "experts … say that

schizophrenia (and all other mental illness) is caused by a combination of biological,

psychological and social factors, and this understanding of mental illness is called the bio-

psycho-social model." Schizophrenia Society of Ontario (2013) states that the causes of

schizophrenia "have something to do with problems involving brain chemistry and brain

structure and, like many other medical illnesses, is thought to be caused by a combination of

problems" while PsychCentral (2014) notes that "there is no known single cause of

schizophrenia. Many diseases, such as heart disease, result from an interplay of genetic,

behavioral and other factors, and this may be the case for schizophrenia as well." However, "in

some small but potentially important ways, the brains of people with schizophrenia look different

than those of healthy people" but "these abnormalities are quite subtle and are not characteristic

of all people with schizophrenia, nor do they occur only in individuals with this illness." An

increasing body of scientific literature does show differences in brain structure in people who

experience psychosis, including in people who have never been treated with psychiatric drugs

(Torrey, 2002), however this proves neither that the brain abnormalities cause or are caused by

psychosis; Bentall (2003) argues that they are caused by environmental stressors. These brain

differences may both be outcomes of an underlying, unknown mechanism. Many other factors

have been linked to higher rates of schizophrenia, including family history (suggesting a genetic

link), being born in the winter or in an urban environment, prenatal stressors, exposure to certain

chemicals, various viruses, and age of father at time of conception (Schizophrenia.com, 2010).

However, none of this necessarily indicates that schizophrenia is a brain "disease", or that

the best way to treat schizophrenia with is with antipsychotic medications. Furthermore, these

studies assumed that the people studied were reliably diagnosed with a valid construct,

schizophrenia, while ignoring the incredibly diverse manifestations of the phenomenon and its inconsistency in diagnosis.

Therefore according to the literature and what according to what is presented to the public, no one knows the cause of schizophrenia, although it does run in families; there are some differences in brain structure, although these do not only occur in people with schizophrenia; and there could be different levels of neurotransmitters or different metabolism of brain chemicals occurring in people with schizophrenia, but we don't know yet. Nonetheless psychosis is framed as a medical condition to the public.

Alternative Theories and Evidence on Psychosis

 Sociocultural, psychological, spiritual, and philosophical theories of schizophrenia and psychosis are prevalent, and exist alongside, or in opposition, to psychiatric and biological theories. Many of them focus on what psychosis feels like to the person experiencing it, as opposed to what it looks like to those on the outside. Some of these theories are developed by people who worked with and interviewed individuals who experienced psychosis; R. D. Laing was the most famous person to do this. Other theories are proposed by the people who have experienced psychosis. Although social stressors and family interaction factors have been demonstrated to play a role in psychosis (Harrop & Trower, 2003; Schizophrenia.com, 2010; Read, Seymour, & Mosher, 2004), psychiatric models generally focus less on these factors or lump them as evidence that, although schizophrenia and psychosis are brain diseases with a genetic component, they can be triggered by stress.

History and social control of madness. Foucault (1964), in his thesis *Madness and Civilization*, outlined his research on the history of 'madness'. Instead of defining madness, Foucault asserted that madness has historically been defined in relation to the particular society.

He traces madness as it developed in the West, noting that according to his research, as leprosy was all but eradicated at the beginning of the Renaissance period, European societies began to separate 'madmen' from the rest of society in place of lepers. For example, according to text of the time, they were segregated onto ships, or into the countryside. By the end of the seventeenth century, the insane were forced into confinement in much of Europe, in some cases into houses of correction along with beggars and unemployed people, where manual labour was expected. By this point, Foucault argues, madness took on a moral component. Because work and labour were increasingly valued, those who were considered mad were framed as immoral and idle. "Between labor and idleness in the classical world ran a line of demarcation that replaced the exclusion of leprosy. The asylum was substituted for the lazar house, in the geography of haunted places as in the landscape of the moral universe…. It was in these places of doomed and despised idleness… that madness would appear and soon expand until it had annexed them" (Foucault, 1964, p. 57). "Madmen" were also treated as spectacle for the public to view and ridicule. Later in the eighteenth century, Foucault (1964) notes that "madmen" were confined away from the public and became shrouded in secrecy.

It follows from Foucault's (1964) historical analysis that, when Western medicine distinguishes the mentally ill from the mentally healthy, part of the differentiation is the level of functional disability of the mentally ill person. If the person is not easily incorporated into paid employment, this is often considered to be a product of mental illness. It is assumed that, if a person was emotionally and mentally healthy, they would be a productive, working member of the society. Work is still considered to be moral and idleness to be deviant, but those who are "sick" are distinguished from those who are just lazy. In a way, the mentally ill are spared from being judged as immoral, but they are also considered to have no agency or control over their

persons; hence they are amoral until they are treated. Treatment success is measured in terms of the degree to which the individual can fit into the working world.

Torrey et al. (1992) support Foucault's argument based on their evidence that the "seriously mentally ill" are criminalized and put in jail at disproportionate rates, often for minor crimes or no crimes at all. The connection between schizophrenia and violence is seriously overrepresented by the media—most people with schizophrenia are not violent (Luhrmann, 2013), although they tend to be victims of violence, including police brutality and killings. This trend is increasing with reduced hospital availability, and is akin to when mentally ill people were jailed at the turn of the nineteenth century, often permanently. Near the end of the 1800s, psychiatric hospitals became commonplace and people were placed there instead. Torrey et al. (1992) note that with the deinstitutionalization movement of the 1970s and 1980s, many people with mental illness began to be criminalized and put in jail again, often for "trivial misdemeanors that are often just manifestations of their mental illness" (p. iv) or for no crime at all. Torrey et al. (1992) argue that this criminalization trend is steadily increasing. This is not to say that many people who spend time in psychiatric hospitals think they are much better; the hospitals are known to be bleak places where forced treatments, confinement, and abuse of power is rampant (Dunn, 1983); people may be confined to these hospitals for the rest of their lives. Deinstitutionalization was framed as celebratory, given the public knowledge of the horrors associated with psychiatric hospitals. However, it is also suspected that deinstitutionalization was a cost-saving decision, and inadequate community supports were put in place, so many people who could not fit within the confines of society became homeless or were imprisoned and criminalized (Torrey et al., 1992).

Schizophrenia was declared to be a biological disease as early as the 1800s, yet psychologists and other theorists went about attempting to find other explanations. There is no record of people being singled out as psychotic, insane, or otherwise until approximately 2000 B.C.E. (Jaynes, 1976). Jaynes (1976) argues that, prior to this time, people constantly heard voices in their heads, which they believed were the "voices of the gods" and acted upon without reflection. This is evidenced by writings prior to this this time, including *The Iliad*. All people were, in a way, "schizophrenic," Jaynes (1976) argues, because at this point one hemisphere of the brain commanded the other and the other hemisphere listened and took orders unconditionally. The concept of "mind" was unknown in ancient texts. Self-awareness and consciousness in the ways we know them today did not develop until the brain was forced to become more flexible due to cross-cultural interactions. Modern-day people with schizophrenia, according to Jaynes (1976), are throwbacks to this "bicameral" mind, which assumes that internal monologue is external, godlike, and all-knowing; thus people assume that the hallucinated voices they hear are omniscient. However, some people can talk back to or reflect on their voices (Intervoice, 2014).

Jaynes (2000) also proposes that schizophrenia must include some biological advantage that has kept it in the gene pool. For example, psychosis has frequently been linked to creativity, and many historical inventors and artists (Koh, 2006), as well as certain philosophers such as Socrates (Skodlar & Jørgensen, 2013), are proposed to have experienced psychosis based on historical accounts. This concept of schizophrenia being somehow biologically advantageous or associated with creativity is quite popular. John Nash, the Nobel Prize-achieving mathematician upon whom the film *A Beautiful Mind* was based, stated in an interview (Hegarty, 2005): "But I

can see there's a connection between not following normal thinking and doing creative thinking. I wouldn't have had good scientific ideas if I had thought more normally."

   Evidence against psychiatric models. Bentall (2003) argues that, with every biological marker that is found to be associated with schizophrenia, it is often incorrectly assumed that this is proof that schizophrenia is a disease of the brain, independent of the environment. This is faulty science according to Bentall (2003), who notes that in every case, there could be an alternate explanation: that the biological markers are responses by the brain to environmental and social factors, and that they may co-occur with but not cause psychosis, which he argues is related more by faulty reasoning and assumptions on the part of the person with psychosis.

   Whitaker (2010) writes a troubling review of psychiatric drugs, from antipsychotics to mood stabilizers to antidepressants. He reports that most studies on drug effectiveness are short term, and long term effects are rarely studied. Originally in the 1940s and 1950s, antipsychotics, then called neuroleptics, were acknowledged among psychiatrists to do damage to the brain—to produce similar effects as a lobotomy—but these effects were considered by doctors to be preferable to madness. One of the early antipsychotics, chlorpromazine (Thorazine), was advertised as a drug that deadened emotional response and motivation. Antipsychotics were popularized specifically because they produced compliant and calm patients.

   Whitaker (2010) reports on the development of the "chemical imbalance" theory of psychiatric drugs. In the case of antipsychotics, researchers surmised that they blocked the function of dopamine in the brain, based on the fact that antipsychotics produced Parkinson's-like symptoms, and based on the knowledge that Parkinson's disease was associated with the death of dopamine neurons in the brain. On the other hand, amphetamines, drugs that caused some symptoms of psychosis, were known to increase dopamine activity in the brain. From this

information, researchers surmised that psychosis itself was caused by a disorder in dopamine activity. This "chemical imbalance" theory has been thoroughly absorbed into the public psyche. However, Whitaker (2010) argues that the pharmaceutical industries indoctrinated the public and doctors alike with this message despite inadequate evidence. His review of the literature shows that the majority of studies found no significant difference in dopamine levels in the brains of people with schizophrenia. In some studies, there were increased dopamine receptors found at autopsy in the brains of people with schizophrenia, but experiments on rats found that it was antipsychotic drug use that corresponded with this increase in receptors. These studies were carried out in the 1970s and offered evidence against the chemical imbalance theory. Whitaker (2010) cites psychiatrists who, in the 1980s and 1990s, stated outright that the dopamine hypothesis for schizophrenia had been debunked, yet "the public continued to be told that people diagnosed with schizophrenia had overactive dopamine systems, with the drugs likened to 'insulin for diabetes'" (p. 77).

The newer, "atypical" antipsychotics were advertised as not causing or being associated with one of the most debilitating side effects of older antipsychotics: extrapyramidal symptoms such as involuntary movements, stiffness and rigidity, and tardive dyskinesia. However, Cohen (2002) notes that the risks of newly marketed drugs is often understated and the benefits overstated. There is evidence of skewed or selectively published studies about the effects of psychiatric drugs, given that the funders for these studies tend to be pharmaceutical companies instead of independent third parties.

This demonstrates that the public is continually misled by the contested chemical imbalance theory. The theory remains part of public discourse, reinforced by the media and drug companies. There are obvious possible reasons that drug companies would continue with the

mantra that mental illness is a condition that requires ongoing medicinal treatment: they need a

justification to sell more drugs. Aviv (2010) notes that research is being done on whether people

showing pre-psychotic symptoms should be given antipsychotics to reduce the risk of psychosis.

However, Whitaker (2010) collects data that suggests that brains adjust to psychiatric drugs in

ways that counteract any antipsychotic changes they make to the neurotransmitter system. For

example, the brain of a person taking an antipsychotic will produce more dopamine in order to

return to its pre-drug equilibrium (Whitaker, 2010). When people then attempt to withdraw from

psychiatric medication, they often experience a severe return of the symptoms they were

medicated for in the first place. Medical knowledge dictates that this is a return of psychotic

symptoms and further proof that medication is required, but Whitaker (2010) proposes that the

psychosis is due to a withdrawal of medication. If this is the case, there could be a concern that

people in a pre-psychotic state who are given antipsychotics may become more at risk. Cohen

(2002) notes that antipsychotic medication treatment produces an "obvious treatment-induced

disease, accompanied nonetheless by mass professional denial that such iatrogenesis was

occurring" (Cohen, 2002, p. 219). Cohen (2002) also gives multiple examples of methodological

oversights in various studies that may contribute to overstated benefits of atypical antipsychotics

over older antipsychotics or no antipsychotics at all. For example, most studies on psychiatric

drugs are very short-term, yet many patients are told that they should stay on the drugs for life.

In the studies Cohen (2002) reviewed, there was a consistent "failure to distinguish between

'relapse' and 'withdrawal-induced psychosis'". Without antipsychotic drugs to reduce

dopamine, the brain experiences an increase in dopamine reaching receptors, which may trigger

psychosis.

Robbins (2012) argues that despite biological evidence, a review of available studies

finds no consistent organic or biological basis for "the psychoses" (p. 258). Furthermore, normal

and abnormal mental states are determined by culture. However, Robbins (2012) does agree that

psychosis becomes schizophrenia when it impairs with the person's ability to function in society

or take care of themselves. Nonetheless, Robbins (2012) argues that the mechanisms underlying

psychosis are not pathological. Many other theorists, also describe psychosis as an occasional

outcome of normal, healthy mechanisms of the mind, with adaptive value—this will be

elaborated on later.

A number of known risk factors of psychosis suggest that environmental and social

variables may contribute to its development. This does fit within biological theories of

psychosis, since social factors and stressors affect the brain. However, these factors take the

emphasis off the concept of the "illness" being predominantly genetic and individual, and instead

place responsibility on the environment for triggering the development of psychosis. Multiple

studies cited on Schizophrenia.com (2010) finds links between schizophrenia and family conflict

during childhood (Tienari et al., 2004), social isolation (Van Os, Driessen, Gunther, &

Delespaul, 2000), childhood socioeconomic status (Wicks, Hjern, Gunnell, Lewis, & Dalman,

2005), and social stress associated with immigration (Cantor-Graae, Zolkowska, & McNeil,

2005). Immigrants, in particular immigrants of colour, have higher rates of diagnosis in

industrialized countries. This has been proposed to be because of "social defeat," or an abrupt

decrease in social status (Cantor-Graae et al., 2005).

Furthermore, there is evidence that diagnoses of schizophrenia are more frequent in

individuals who resist desired social norms, with little evidence of actual required

symptomology. Diagnosis is also more frequent in oppressed groups. Whitaker (2002) collects

data on racism and classism and their role in diagnosis of schizophrenia in America. In the 1800s, African Americans living in states that had banned slavery, and African American slaves who wanted freedom, were much more likely to be deemed "crazy." Freed slaves, "emancipated from their bonds of slavery, found themselves newly at risk of being locked up in mental asylums" (Whitaker, 2002, p. 171). Those who were hardworking and who accepted their role as second-class citizens were less likely to be singled out. Discourse of the time was that African Americans lacked the capacity to care for themselves once freed, and were at risk of descent into madness and idleness (Whitaker, 2002), as though the two were the same, and as though idleness may not have been related to resistance or lack of meaningful work. Black people continue to be overrepresented in schizophrenia diagnoses to this day, and according to studies they are more likely to be involuntarily hospitalized than white people. According to one study, American psychiatrists were more likely to diagnose a person with schizophrenia if he was a black man (as opposed to a white man, black woman or white woman), when presented with case studies that described the same behaviour, with the only variables being race and sex. The psychiatrists in this study were also more likely to describe the African American men as violent although the description was the same (Whitaker, 2002).

Read (2004d) reports that racism causes psychiatrists to diagnose more severe illnesses to black and other racialized people. The history of seeing black people as insane remains embedded in the biases of medical professionals. This same pattern is repeated among colonized indigenous people, such as the Māori in present day New Zealand. However, Read (2004d) proposes that racism itself may trigger psychotic reactions. I can imagine that chronic racism, in particular covert or denied racism, could influence "paranoid" thinking. "One of the many issues minimized by overemphasis of bio-genetic factors is the role of belonging to a disempowered

group" (Read, 2004d, p. 161). Read (2004d) notes that poor people have always been overrepresented in asylums, and that by 1976, over 50 studies had demonstrated a link between schizophrenia diagnosis and poor socioeconomic class—a stronger link than any other psychiatric diagnosis. In Read's (2004d) review of the literature, childhood-onset schizophrenia was much more likely to be diagnosed in children from poor families. Deprivation appears to be linked to schizophrenia, and a "neutral observer might conclude that schizophrenia, like other expressions of human distress, is caused—at least partially—by growing up with the disadvantages and stresses associated with poverty" (Read, 2004d, p. 164). There are of explanations for this that reinforce the biogenetic theories of schizophrenia, and some of them are quite contentious. The most common one is that schizophrenia causes poverty; that is, people with schizophrenia cannot thrive in the job market. This may be true for some people, especially those who have internalized a chronically "ill" identity and do not feel hope for recovery. However other studies, Read (2004d) notes, have found that the vast majority of people with schizophrenia occupied the same social class as their parents. Another biogenetic explanation is that poor people deal less effectively with stress; it is not that they experience more stress but that they are more likely to become mentally ill when exposed to stress. Read (2004d) dismisses this as "mental gymnastics designed to prove that the poor do not really experience more stress and if they do it has nothing to do with their 'mental illness'. This is scientifically and morally indefensible" (pp. 167-168). Read (2004d) cites evidence that severe diagnoses like schizophrenia were more likely to be assigned to poor people than people in higher socioeconomic classes despite the same symptoms, and that hospitalization and purely physical treatments such as medications, electroconvulsive therapy, and lobotomy were more likely to occur among poorer patients.

Existential and psychological themes of psychosis. Williams (2012) compiles a

compelling theory of psychosis as the outcome of an extremely stressful event that causes an

existential crisis in the sense of self, or ego. He reviews literature that suggests that taking

antipsychotic medication is associated with a more chronic course of schizophrenia and proposes

that these drugs create, rather than treat, a "chemical imbalance." Whitaker (2010) is well-

known for his thorough literature review that supports this hypothesis and influences his anti-

psychiatry stance. Williams (2012), who overcame an episode of psychosis himself, draws on

the work of existential philosophers Rollo May and Irvin Yalom, as well as Buddhist

philosophies of the nature of the mind and the self. He also interviews individuals who have

experienced psychosis and finds that their experienced shared many commonalities that are

usually not described in psychiatric literature, but can be explained if psychosis is viewed as the

a survival strategy brought on by an existential crisis. Williams (2012) describes psychosis as "a

desperate survival strategy brought on intentionally by one's very own being" (p. xxii).

However, he does not mean that psychosis is brought about in conscious awareness, but rather

that it is brought on by the psyche, or the innate intelligence of the self. He uses multiple terms

to create a complete definition of psychosis: *consensus reality* refers to the beliefs that are

determined by society to be true and valid, and an *anomalous experience* is "a subjective

experience (typically either a belief or a sensory experience) … that is considered invalid within

the framework of consensus reality…" (p. 13). Williams (2012) then notes that psychosis is

nothing more or less than anomalous experiences that are distressing or limiting to the

individual. That is, what is defined as psychosis is determined by cultural norms.

According to Williams (2012), experiences of psychosis occur when the individual

experiences intolerable or overwhelming experiences of isolation, or alternately of engulfment or

oneness with others, that threaten the existence of the self. This causes a dissolution of the individual's *cognitive constructs*—that is, the boundaries that the mind creates to separate objects or concepts. Williams (2012) notes that this causes extreme states of distress and confusion, but that this process is ultimately adaptive if the individual is given time and support in order to redefine cognitive constructs for themselves in a more flexible way that allows their ego to tolerate a greater variety of experiences. Williams (2012) also found through his interviews that many individuals had recovered, reintegrated fully into society, were not taking medication, and felt that they had gained positive effects from their experiences with psychosis. Williams (2012) proposes differences between spiritual experience and psychosis, but argues that the distinction may not be clear-cut.

The existential components of psychosis are important to many theories. Stanghellini and Ballerini (2007) interviewed patients with schizophrenia and schizoaffective disorder extensively to determine if they shared any commonalities in values. They found themes in these interviews that many of the individuals were preoccupied with existential and ontological questions. They "purposely oriented toward being against the ordinary mode of existence… they strive to be faithful to their own eccentricity" (p. 133). Furthermore, Stanghellini and Ballerini found that the process of developing psychosis involves significant doubt in what is socially considered to be commonsensical. "Both the feeling of perplexity, i.e., the depths of doubt that occurs during the initial phases of schizophrenia, and the deviated behavior during the premorbid period can be seen as an expression of a crisis of participation in common sense" (Stanghellini & Ballerini, 2007, p. 133). In other words, people who develop schizophrenia do so when they experience doubt over the objective truth of socially accepted reality. This leads to some of the "deviated behavior" and "eccentricity" that occurs.

Bargenquast and Schweitzer (2012) also focus on the experience of self as it relates to psychosis. They study sense of self and self-experience in schizophrenia and state that schizophrenia is primarily a disturbance of the ability to construct narratives about oneself and to utilize metacognition, or awareness of and ability to regulate one's own thoughts. Williams (2012), as well, argues that the only difference between a "spiritual emergency" and psychosis is that a psychotic experience involves a weakened "observing ego," that is, "the capacity … to question and/or notice any differences between what one is experiencing/believing and what others may be experiencing/believing" (p. 94). Therefore according to Williams (2012), in psychosis, the individual is not aware that their beliefs may be subjective.

Harrop and Trower (2003) view difficulties with the construction of a "sense of self" in late adolescence and early adulthood as a key component of the development of schizophrenia. They note that people may or may not have a biological predisposition to schizophrenia, but there has been inadequate scientific evidence that structural changes in the brain *cause* psychosis, instead of being a *consequence* of psychosis or of antipsychotic drugs. Harrop and Trower (2003) view psychosis as a type of reaction to the social environment: either the person with psychosis feels ignored and this translates to feelings of nonexistence, or the person feels engulfed by others. Examples given of people with paranoid schizophrenia suggest that many of them fear being controlled or dominated and have "delusions" of control being exerted on them from the external world, and Harrop and Trower (2003) propose that these individuals may have had relationships with particularly domineering people; this was somewhat supported by their interviews although it reflects a family-blaming perspective that has fallen out of favour.

Harrop and Trower (2003) cite a study from Australia that found that 10% - 50% of 16-year-olds showed prodromal symptoms of psychosis (depending on the strictness of criteria that

was used). Prodromal symptoms are quite vaguely defined, but include: emotional changes such

as depressed or anxious mood; cognitive changes such as difficulty concentrating; feeling

different from or suspicious of others; changes in perception or in somatic sensations; and

"preoccupations such as increased concern with spiritual/philosophical issues" (Mental Health

Evaluation and Community Consultation Unit, 2000, p. 17), which for some reason warrant

pharmaceutical treatment. Aviv (2010) cites statistics from a first episode psychosis clinic

wherein 35% of the people who came to the clinic with prodromal symptoms eventually had a

"psychotic episode" (and 43% of those who used cannabis or other psychoactive drugs did; the

link between cannabis and psychosis is currently under scientific scrutiny). Since the majority of

people with prodromal (pre-psychosis) symptoms apparently do *not* go on to develop

psychosis—the generally accepted statistics are that 1% of the human population worldwide has

schizophrenia (National Institute for Mental Health, n.d.) and that 3% experience at least one

episode of psychosis over the course of their lives (Canadian Mental Health Association,

2013)—this means that the thoughts and perceptions that occur in the prodrome do not

necessarily lead to psychosis and, Harrop and Trower (2003) argue, may be a common part of

adolescence. They are not the only ones to view psychotic thinking as not clearly demarcated

from "normal" thinking; Bentall (2003) also views psychotic thinking as existing on a spectrum.

Harrop and Trower (2003) proposed that youth who develop psychosis may be experiencing

extreme versions of normal adolescent conflicts. They note that, while in adolescence people

commonly renegotiate their boundaries and independence, the adolescents they interviewed who

were experiencing psychosis were typically more likely to avoid conflict or disagreements with

their parents, and to idealize their parents and avoid criticizing them. Alternatively, some young

people interviewed appeared to have individuated from their parents but showed extreme

idealization of their peers, combined with difficulty forming relationships with them; this led to excessive self-focus and thwarted self-assertion. Therefore, they suggest "that people who develop a psychosis get trapped in [the adolescent] period of their lives" (Harrop & Trower, 2003, p. 51). Harrop and Trower (2003) propose that youth who develop psychosis typically have difficulty developing autonomy, independence, and cognitive boundaries from their parents or peers despite this being, according to the authors, and biologically ingrained need. They cite evidence that young adults who continue to live with their parents have a higher rate of "relapse" and psychosis. A major area of research is of the family that is high in "expressed emotion," which refers to the family expressing strong negative opinions or "emotional over-involvement" over a family member's psychosis, and which is linked to higher rates of relapse. Even in mainstream medical rehabilitation for people with psychosis, families are supported in changing this behaviour. Read, Seymour and Mosher (2004) argue that, given the evidence for links between childhood trauma and abuse and psychosis, it is curious that this potential contribution is generally not mentioned in psychoeducation. Families, they argue, feel suspicious when they are told that they are not "at fault" for a family member's psychosis, yet they nonetheless can worsen it once it develops. Read et al. (2004) argue that the role of the family is often not mentioned due to a movement to reduce blame and social marginalization of the family, which was common when psychoanalysis was prevalent. Although this movement to reduce family blame had excellent intentions, Read et al. (2004) argue that it also covered up the evidence for the potential of social factors to psychosis.

Harrop and Trower (2003) found that depression, egocentricity, and "personal fables" of invulnerability and uniqueness are common experiences of most young people, but often these experiences diminish in late adolescence. The young people they interviewed who experienced

psychosis, however, show signs of continuing to experience these internal conflicts. For example, "delusions of grandiosity," common in people with schizophrenia, could be seen as an extreme version of adolescent egocentricity (referring to excessive self-focus, not selfishness). Indeed, one of the main diagnostic criteria for schizophrenia in DSM-IV is hearing a hallucinated voice that provides a "running commentary" of the individual's actions. Often this voice can be very critical (Harrop & Trower, 2003) and tends to create feelings of objectification and distress in the person. This is proposed to be a result of excessive self-consciousness. They propose that self-consciousness may prevent people from developing awareness of the thought processes of parents and peers enough to successfully de-idealize them.

Harrop and Trower (2003) borrow from Sartre, Laing, and Descartes to propose that "the self" exists only as a product of one's self-presentation to others and their reflections back to the individual. Self is constructed, and constructing a sense of self is one of the most prevalent drives of humans. People have an *existential motive* to present their self to others as they wish to be seen, and to have this affirmed. Harrop and Trower (2003) note that R. D. Laing, an important theorist on the existential causes of psychosis, proposed that extreme *ontological insecurity*—the insecurity of not existing—is caused by a lack of significant others to affirm the person's presented self, and can trigger psychosis. In a certain subgroup of people with psychosis, Harrop and Trower (2003) argue that this lack of affirmation may trigger rage and violence, but typically the people with psychosis whom they interviewed experienced tremendous guilt and an inability to assert or stick up for themselves in any way; they assumed that others were infallible and correct, even if these others had negative viewpoints of the person with psychosis. If Harrop and Trower (2003) are correct that people with psychosis are highly

reliant on others to define their selves, then I believe that it follows that these people would be exceptionally vulnerable to any messages they receive about being "different" and incurably ill.

Harrop and Trower (2003) conclude that psychosis represents an impasse in the attempt to develop self-identity. People with psychosis are known to have views of themselves that tend to be extreme—for example, that they are purely evil, or that they are omnipotent and possessing special powers. Evidently these beliefs can occur within the same person (Williams, 2012; Harrop & Trower, 2003). Harrop and Trower (2003) note that, if they do not feel omnipotent, they may feel at the mercy of the outside world and have paranoid suspicions of persecution or surveillance, or they may feel powerless, isolated, and perhaps like they do not exist. Williams (2012) also describes the experience of psychosis, based on his own experience and on interviews, as an oscillation between extremes: of omnipotence and powerlessness, of individuality and unity, of fear and euphoria. Williams (2012) proposes that a weakened ability to filter information, due to a weakened "ego," allows these extreme oscillations and environmental sensitivity. Harrop and Trower (2003) agree that individuals with psychosis appear to have an inadequately formed sense of self in relation to the rest of the world. I find this information fascinating but culture-bound. I am curious how this theory would hold up in "collectivist" cultures, which are said not to value individuation as highly, but I could not find studies on this. Some cultures, as far as I know, have no word or conception of "self," and others, such as cultures with strong Buddhist beliefs, believe that it is beneficial to view the self as an illusion, and yet these viewpoints do not cause higher rates of psychosis as far as I know.

I believe that these theories of schizophrenia are important because they rely on existential themes and of processes of identity formation that tend to occur not in isolation but in the social world. Focusing on these processes and deconstructing them can offer a novel way of

looking at the way in which psychosis develops in the social world, and can offer new paradigms with which to view "treatment." Harrop and Trower (2003) conclude that psychosocial treatments may be effective at reducing self-focus, de-idealizing others, and challenging the content of hallucinated voices, and they recommend that these treatments be studied.

In contrast to this idea that psychosis is a product of attempting to find meaning in isolating experiences, Morgan (2010) discusses the concept, proposed earlier in the twentieth century, that schizophrenia is a form of "deadened life." Morgan (2010) theorizes that a person with schizophrenia has become an object to themselves, and this is the cause of the extreme isolation and suffering in psychosis. Morgan (2010) argues that schizophrenia, as a construct, refers to alienation from life. Sass and Parnas (2003) also argue that schizophrenia becomes a viable construct when its extremely diverse features are all explained by an underlying disorder of consciousness and self-concept. They also agree that schizophrenia reflects a breakdown in the individual's sense of being a subject. A person with schizophrenia, they argue, suffers from a loss of viewing themselves as vital or as acting in the world. Sass and Parnas (2003) argue that a phenomenological approach is required in order to explain schizophrenia, in light of schizophrenia's lack of validity when observable symptoms are the sole focus. The subjective experience is paramount to defining the construct, they argue.

Theories of "symptoms" of psychosis. McCarthy-Jones, Waegeli, and Watkins (2013) describe hearing voices (also known as *auditory hallucinations*) as being explained through medical, psychological, or spiritual means at varying times, noting that "spiritual accounts look for a meaning that goes beyond misguided molecules, disordered dipoles, and contorted cognitions" (p. 247). They found through a review of interviews that auditory hallucinations varied considerably in the extent to which they were comforting or frightening to the voice

hearer. According to some interviewees, voices came from a higher, guiding power to provide

comfort and company in times of loneliness (which is much of the time for many people with

psychosis). McCarthy-Jones et al. (2013) note that voices may attempt to make meaning of

significant life experiences. It is important to consider the implications of the medicalization of

voice-hearing and other psychotic "symptoms," and the way psychiatry silences the spiritual and

existential meaning that many individuals and cultures interpret hallucinations to have.

McCarthy-Jones et al. (2013) note that it is beneficial to some people with psychosis, but not

others, to view their experiences as spiritual, just as some people but not others appreciate

viewing psychosis as a disease. They attempt to distinguish between "spiritual" and "psychotic"

voices, but argue that this may depend on culture. Individuals who experience "visions," hear

voices, or who speak in riddles or metaphors were and are venerated as shamans in certain

cultures, some of whom purposefully take psychoactive drugs to stimulate psychotic experience

(McCarthy-Jones et al., 2013). However, in other belief systems, people experiencing some of

the more frightening aspects of psychosis have been labeled as witches, or as experiencing

demonic possession. Ultimately, McCarthy-Jones et al. (2013) suggest that a postmodern

perspective on voice-hearing, wherein the true nature of the voice is less important than the way

the voice hearer interprets it, is more helpful to voice hearers.

Others (Escher, n.d.) argue that hallucinated voices serve a purpose and are not

necessarily pathological or evidence that psychosis will worsen, yet conventional approaches that

focus on "symptom" reduction, such as antipsychotic drugs, operate on the premise that voices

are meaningless. However, Escher (n.d.) argues that hallucinated voice are indicators of an

environment that is not meeting a person's needs. Escher (n.d.) cites studies that found that

antipsychotic drugs do not eliminate hallucinated voices in 30% of people, and that hallucinated

voices are often associated with repeated or prolonged trauma, such as childhood or spousal abuse or neglect, or ongoing social ostracization (an example given was being forced to hide one's sexual orientation). Bentall (2003) suggests that people who develop psychosis may be more sensitive to their interpersonal environments, meaning that events or interactions that others may not interpret as traumatic may strongly affect people who experience psychosis. Bentall (2009) outlines evidence that trauma causes intrusive thoughts for many people, which in the case of psychosis appear to be an external voice. Bentall (2009) also argues that repeat experiences of victimization or extreme insecurity make one more likely to anticipate future threats, which can lead to persecution delusions in certain people.

Luhrmann (2013) notes that hallucinated voices are universal to schizophrenia, but their content varies according to cultural themes. Although most people with schizophrenia are not violent and are more likely to be victims of violence, not perpetrators, those who do commit violence are often under the influence of drugs, and may experience hallucinations commanding them to do so. "An unsettling question is whether the violent commands from these voices reflect our culture as much as they result from the disease process of the illness" (Luhrmann, 2013). Luhrmann (2013) found that, although people studied both in India and in America experienced hallucinated voices that were demeaning and violent, those of his American sample had command hallucinations that were much more graphic, and that demanded the voice-hearer commit violence or suicide. In Chennai, India, voice-hearers usually heard commands to do chores or to perform acts that were self-degrading. If these findings are replicated, they may suggest that the content of psychosis is an indicator of dominant cultural values.

Davidson (2003) sought qualitative information on recovery from psychosis by speaking with people about their subjective experiences before giving his own interpretation. One woman

Davidson (2003) interviewed showed a characteristic symptom of psychosis, *avolition* or lack of action (in this case, for warming up her food before eating it). Instead of viewing this as a symptom of a disease, however, the interviewee's explanation—that she knew she had to eat, but felt so empty and lonely eating alone that she had no motivation to prepare a warm meal—made her avolition appear not to be evidence or a symptom of a dysfunctional brain, but of evidence of a person suffering from social isolation and a subsequent lack of motivation to view eating as having any value outside of providing nourishment.

Other theorists describe other symptoms of psychosis, such as delusions, as attempts to explain troubling changes in perception and bodily sensations, which may indeed be a result of physical changes in the brain. The meanings constructed around these changes, however, create some of the primary symptoms of psychosis, which are idiosyncratic and disturbing to others. Aviv (2010), in her article on new research in preventing psychosis, interviews a young woman who perceived objects around her not as solid, but as "tiny, buzzing particles" (p. 35). The young woman began to notice details of objects that others would find unremarkable. She became obsessed with the strangeness of aspects of the world that were typically unquestioned. She became focused on her thoughts and they began to feel external to her; eventually they sounded like voices. Her "psychotic" explanations that followed—including that she had been given a special task to uncover strange truths of the world—were explanations for the perceptions she experienced and for the fact that no one else was experiencing them. Aviv (2010) states that many of the young people she interviewed who went on to develop psychosis felt that there was an element of choice in exploring their unusual trains of thought—that is, that they were aware of uncomfortable changes in their perception, and they were aware of the eccentricity of their explanations for these changes, but they felt compelled to continue down

these lines of reasoning. Furthermore, people who go on to develop psychosis often grapple with philosophical, nihilistic, and existential questions (Aviv, 2010) that others typically avoid. The individuals interviewed were simply questioning taken-for-granted ideas of their culture.

"Insight" as social control. It is proposed by psychiatrists that many people with severe mental illness lack "insight" into the fact that they are sick, causing them to resist treatment. According to Dolson (2005), insight in relation to psychosis is defined as possessing the appropriate attitude towards a condition; that is, people with insight accept that their experiences are indicative of illness, and they comply with treatment. Consequently, the treatment goal of increasing insight is actually the goal of increasing acceptance of a "sick" role and the need for treatment as outlined by professionals. Dolson (2005) argues that insight is a construct that is used to enforce medical understandings of psychosis. Individuals whose experiences are medicalized are not granted validation of their own constructed meanings. Dolson (2005) notes that the concept of insight involves a "value judgment" (p. 78), so that the individual's own interpretations of their experiences are assumed to be further symptoms of lack of insight. Dolson (2005) notes that the medical concept of insight leads to silencing of explanations of self that are shaped through the individual's cultural or intersubjective context.

Buck et al. (2013) note that with increased "insight" that one is "mentally ill" often comes depression and suicidal ideation as the person realizes that their reality is false and they are an "ordinary, though agentic, person" (p. 134). Buck et al. (2013) are compassionate regarding the suffering faced by people in recovery, but do not question the need for increasing "insight". Buck et al. (2013) discuss typical feelings of loss or shame that occur when people gain insight, having to make new sense of the world and grieve "the loss of previous, often idiosyncratic or psychotic, ways of making meaning of the world" (p. 136); the anxiety of

viewing oneself as a person with capabilities and hence responsibilities, instead of as a sick or disabled person; the pain of missed opportunities and difficulties with social interaction; the loss of company from hallucinated "voices"; the loss of being special or important in some way; and disillusionment with the mundaneness of everyday life. Buck et al. (2013) describe the substantial reconstruction of identity that must come as a person begins to view themselves as having suffered a sickness: the more they viewed themselves as a helpless "patient," the more they experience anxiety with increasing self-awareness and recognition of their own potential. Often the delusions they experience, Buck et al. (2013) note from interviews with service users, provide some protection from unbearable anxiety, and once these delusions are invalidated the person is left feeling extremely powerless. Buck et al. (2013) provide suggestions for professionals on supporting people in constructing stories to make sense of pain, but also to promote a richer and more integrated sense of self, with realistic future goals. It is worth considering whether people "resist treatment" in part due to some of the reasons Buck et al. (2013) presented.

Voices of Consumers and Survivors

The phenomenological study of psychosis may be empowering because it prioritizes experience over professional knowledge. Large amounts of information from consumers and survivors of psychiatric diagnosis and treatment can be found, but they occupy a "fringe" position and are subject to ridicule. Compared to the theories of psychosis that reach a mainstream audience, the experiences of people who have actually experienced psychosis are far rarer due to these people's lack of "professional" knowledge and mass audience. Furthermore, the concept of psychosis as a disorder that destroys a person's ability to distinguish fantasy from reality is a very effective way of discrediting their abilities to define and name their own

experiences. People experiencing psychosis are framed as being irrational, speaking nonsense, and having a disrupted sense of self. Since during a psychotic episode many experience "thought disorder," which makes their sentences difficult to comprehend, it is assumed that these sentences are therefore conveying no meaningful information.

Reports by people who have experienced psychosis outline extremely diverse ways of making meaning and explaining experiences. Overall, however, there appears to be a significant reluctance among people who have experienced psychosis to view it entirely as an "illness." *Phoenix Rising: The Voice of the Pychiatrized* was a journal with consumer and survivor perspectives that was published from 1980-1990. According to one of their editorials:

> "schizophrenia" is just a catch-all phrase used by psychiatrists to identify and control any kind of behaviour that doesn't conform to their notions about 'normal' behaviour…. We believe that many people labeled "schizophrenic" are simply acting out some of the rage, confusion, hopelessness and fear that comes from living in a society where people are rarely allowed to express their true feelings. In this sense, "schizophrenia" can be seen as a … survival instinct and… a testament to the strength and will of the survivor…. "Mental hospitals" … are nothing more than control centres where people's behaviour is inhibited and modified (Dunn, 1983, p. 2).

People who have been diagnosed with mental illnesses such as schizophrenia sometimes view themselves as "survivors," not of the disease but of the violence of psychiatry or criminalization (Farber, 2012). The Mad Pride movement developed to fight for the rights of diagnosed people, not just to be free from the harm of certain psychiatric treatments but also for "the right to be different" (Farber, 2012, p. 1). Romme, Escher, Dillon, Corstens, and Morris (2009) collect 50 personal accounts of recovery from psychosis and learning to cope with

auditory hallucinations. While the medical model usually maintains that people with psychosis

recover due to medication and psychosocial rehabilitation, Romme et al. (2009), as well as

Chadwick (2009) and Williams (2012), offer perspectives from people who incorporated aspects

of their psychosis into their personal growth and recovery process. In Chadwick (2009) and

Williams (2012), survivors maintain that their psychosis was caused by significant existential

anxiety. Working through this existential crisis led to valuable insight and growth, despite some

negative experiences.

In *Crooked Beauty* (Rosenthal & McNamara, 2011), a documentary about madness,

hospitalization, trauma and medication, the narrator Jacks Ashley McNamara describes their

experiences with bipolar disorder and psychosis. ("They" is McNamara's pronoun of choice.)

McNamara, like so many other survivors of mental illness, attributes mad experiences to trauma

as opposed to a genetic brain disorder. McNamara also links madness with "creativity"—a

connection that is drawn repeatedly by consumer survivors—and McNamara notes that when

they are feeling well they experience less desire to be creative. McNamara states:

> The message I got when I was 19 was: I'm a mood disorder with legs. Your life is insane
>
> because you have a biochemical problem. If you take these drugs religiously for the rest
>
> of your life your life won't be insane…. Mental illness does not exist in a vacuum.
>
> Saying that it is nothing but a biological brain disorder lets everybody off the hook and
>
> makes it this situation where it's just the individual versus his or her inevitable biological
>
> madness…. a lot of people who get labeled as mentally ill in our society have really
>
> broken hearts. A lot of the behaviours and the attitudes that I had before I got locked up
>
> in the psych ward and given a diagnosis had a lot to do with trying to escape from my
>
> sadness…. If I was determined to live my life in a city and to work a really intensive

steady job in an office, I think I would have to take medication to do that, but I don't

think that fact means that I have a disease. It means that it would take a pharmaceutical

substance to override my instincts to make me capable of fitting into a system that was

not designed for someone with a spirit like mine…. I'm just really sensitive and my

moods shift in ways that I don't keep a rhythm that fits with the clock of capitalist society

(Rosenthal & McNamara, 2011).

   McNamara's narrative speaks to the biological needs of people—their sensitivities to the

natural world—while also contesting the purely biological explanations of madness. It also

speaks to the way a person with a so-called mental illness viewed medication; not as a treatment

for illness but as a suppressant of their ingrained instincts. McNamara is the founder of The

Icarus Project, an online community devoted to "navigating the space between madness and

brilliance" (The Icarus Project, 2013a). In this community the connection between madness and

creativity is heavily enforced. Different categories of the discussion forums include:

"Experiencing 'Madness' and 'Extreme States'"; "Stand Up For Your Rights: Oppression,

Advocacy and Activism", which specifically mentions racism, classism, and police violence and

harassment; "Psychiatric Treatment and Mainstream Treatment" including a forum topic called

"Psychiatrists Say the Darndest Things"; "Alternative and Holistic Treatments"; "Alternate

Dimensions or Psychotic Delusions?"; "Deconstruct the Media"; "Relationships"; "Mad QT",

which is for queer, trans*, lesbian, gay, bisexual, and asexual people and other minorities of

sexual orientation and gender expression; a self-medication forum; and a spirituality forum,

among others. Many discussion topics are posted by individuals who believe they are in a

psychotic state and are seeking guidance from other community members. Some people post

questions on how to safety stop taking their medications, but others also ask others to support

their philosophical concerns when the general community and psychiatry might consider these thoughts too alarming or delusional to entertain. Many people posting on the forums do take medications and note a wide range of reactions to them, including ambivalence, gratitude, and fear or resentment over their side effects. Many people prefer "natural" alternative medicine to psychiatric drugs. Although The Icarus Project (2006) views madness and "extreme emotional distress" as "dangerous gifts", it is open to community members using psychiatric drugs in order to take care of themselves. Their Mission Statement declares: "We recognize that we all live in a crazy world, and we believe that sensitivities, visions, and inspirations are not necessarily symptoms of illness. Sometimes breakdown can be the entrance to breakthrough…. we challenge standard definitions of psychic difference as essentially diseased, disordered, broken, faulty, and existing within the bounds of DSM diagnosis…." (The Icarus Project, 2006). There is also recognition that even in the community of those who experience "extreme states," certain people have more political power than others, often due to education, race, opportunities and other forms of privilege. "Those most marginalized at the intersections of extreme distress and disadvantage are the least likely to be heard. When we're not careful, those of us with more privilege—including by the virtue of experiencing less debilitating forms of distress—wind up speaking for folks whose experiences are not much like our own" (The Icarus Project, 2013). It is acknowledged that there are varying degrees of madness, and certain people can communicate better with the mainstream world than others.

At least two movements have emerged due to the limitations of psychiatry: the Mad Pride Movement and the Recovery Movement. Mad Pride, whose current incarnation began developing in the 1970s (Farber, 2012) emphasizes the value of the insight that is gained in states that could be described as psychotic, which could trigger social change if they were not

suppressed by psychiatry. Mad Pride movements believe that wisdom is found altered states of

consciousness, and furthermore that religious prophets would be considered psychotic by

psychiatric standards. In Mad Pride, the term *madness* refers to "'altered states' of

consciousness… that are nonrational…. *Madness*, as I use the term, is neither evaluative or

normative—but it can be *either* good or bad or neither—but I argue that in … most cases, such

altered states, however painful, are 'good,' meaning that they are potentially valuable

experiences" (Farber, 2012, p. 3). Those in the Mad Pride Movement reject any form of

psychiatry and believe that psychiatry will eventually be exposed as a farce, despite many people

do feel that they benefit from medication. According the Mad Pride Movement, medication is

producing a chronically disabled population. This is supported by research by Whitaker (2010),

an antipsychiatry researcher but not a Mad Pride activist.

The Recovery Movement argues that people with mental illness can achieve a degree of

functional recovery and integration into society, and seek to provide psychoeducation on the

possibility of recovery. Therefore the Recovery Movement includes a general belief that

psychosis is potentially harmful, abnormal and limiting and should be managed, and that

recovery involves overcoming denial of being ill and at least partial remission of symptoms

(Roberts & Wolfson, 2004). However, there tends to be a focus in this movement on a "holistic"

or existential approach to recovery, including finding meaning and purpose in life, maintaining

hope and healthy social contact, and "connecting with one's aliveness" (Williams, 2012, p. 263),

which can be hampered by the tranquilizing effects of antipsychotic drugs. There are various

interpretations in this movement of whether psychosis is an illness, of the value and legitimacy

of insights gained during psychosis. There are also various levels of acceptance of psychiatry

and of incorporating psychiatric drugs into recovery. For the most part, the Recovery Movement

tends to focus on social support, "moving from withdrawal to engagement and active participation in life" (Ridgway, 2001, p. 237), "active coping rather than passive adjustment" (p. 238), "no longer viewing oneself primarily as a person with a psychiatric disorder" (p. 239) and "moving from alienation to a sense of meaning and purpose" (p. 240). Bentall (2009) describes studies where people with psychosis found that unemployment impeded their recovery. This contrasts with the Mad Pride Movement, where madness becomes a part of one's identity. Patricia Deegan (1995), a prominent recovery advocate and psychologist who was once diagnosed with schizophrenia, outlines the ways in which psychiatric medications could be included in a recovery plan that focuses on self-determination, coping and skills. Deegan (1995) notes that people have a right to express concerns about psychiatric drugs and the ways they may change one's personality. Deegan (1995) argues that recovery must involve people choosing their supports and being able to rely on them in an ongoing way, instead of the end goal being a reduction in support systems.

An increasing number of mental health doctors, psychiatrists, and other professionals have admitted to having experienced psychosis and psychiatric diagnosis. One example is Rufus May, a clinical psychologist in England who, as a youth, experienced psychosis and recovered after discontinuing psychiatric services and medication. He stated: "I came very close to developing a long-term sick role as a 'schizophrenic' because the expectation all around me was that I would not be able to rebuild my life…. I was encouraged to passively adjust to a serious 'mental illness' …. The belief held by hospital staff was that I would be powerless to influence the return of psychotic symptoms that could at any moment strike again" (May, 2004). May (2004) found from his research and personal experiences that people who adopted a "mentally ill" identity has worsened depression and weaker "narratives of possibility." May and others

also call for a different approach to delusions, which should not be considered problematic

unless they cause distress. In the foreword to Knight (2009), May stated: "It seems … that

where people get into problems with unusual beliefs, is when they become isolated with their

beliefs and emotions such as fear and anger can then lead to self destructive or occasionally anti-

social behaviour. The … solution to this is to get everybody suspected of having this potential on

long term anti-psychotic medication at levels where they are unable to think for themselves past

the basic functions of eating, washing and sleeping….We discover that many people get on with

their lives as well as holding beliefs others may deem to be highly unusual" (p. 6).

Tamasin Knight, a health practitioner who was previously hospitalized for psychosis,

developed a manual for alternative methods of working with people experiencing "delusions."

The focus is on reducing the person's distress and increasing their sense of control, instead of

attempting to minimize or invalidate the content of the "delusions." Knight (2009) argues

against the typical therapeutic practice of not "colluding" with delusions, stating: "Attempting to

change someone's unshared or unusual beliefs can result in emotional distress arising from the

experience of not being believed… and so result in alienating the person…. [An] individual's

unusual beliefs… can often make up a large part of their life and identity" (p. 13). Knight (2009)

recommends that people experiencing distressing delusions should be provided with strategies

for reducing anxiety about them. For example, people experiencing religious delusions may be

encouraged to seek spiritual guidance related to the content of their thoughts, although Knight

(2009) stresses that individuals who are accused of being evil or sinful should avoid that

particular religious leader. Typical anxiety management or post-traumatic stress disorder

management strategies can be used, even if the anxiety or trauma is related to something

considered delusional, such as an alien abduction story. Knight (2009) gives an example of a

person who believes that a particular hat protects her thoughts from being broadcasted. Instead

of being encouraged to accept this belief as a delusion or to take medication to reduce delusional

thoughts, this person is simply encouraged to wear the protective hat and get on with her life.

Furthermore, Knight (2009) argues that it is extremely relieving for individuals to have others

believe their concerns; others should listen to them talk about their beliefs without attempting to

alter them. Knight (2009) acknowledges that it may be very difficult to accept these beliefs, but

strategies to help individuals to manage the anxiety caused by delusions is preferable to forcing

them to accept consensus reality, at the risk of causing depression and loss of identity.

Luhrmann (2013) reports on recovery groups that recommend that voice-hearers change

their relationships to their voices, particularly disturbing voices, in order to reduce their

influence. Unlike Western medicine, which views voices as meaningless at best, dangerous at

worst, this viewpoint encourages voice-hearers to seek to understand and negotiate with voices.

People report that "their voices diminish, become kinder and sometimes disappear altogether—

independent of any use of drugs" (Luhrmann, 2013). The International Hearing Voices Network

(Intervoice, 2014) recommends this approach, as fearing voices tends to make them appear to be

more in control. "We understand 'voices' to be real and meaningful, something that is

experienced by a significant minority of people, including many who have no problems living

with their voices. Our research shows that to hear voices is not the consequence of a diseased

brain, but more akin to a variation in human behaviour …. It is not so much the voices that are

the problem, but …difficulties … in coping with them" (Intervoice, 2014).

Chapter Four: Discussion

When I conducted my review of the varying approaches to psychosis, I found that there

was a staggering amount of information and opinions to be found, from entire individual books

on Mad Pride (Farber, 2012), to existential, psychological, social and spiritual theories on

psychosis (Williams, 2012; Bentall, 2003 & 2009; Harrop & Trower, 2003; Geekie & Read,

2009; Read, Mosher & Bentall, 2004; Chadwick, 2009), to books that seek to expose the

violence of past psychiatry and the systemic cover-up of evidence that psychiatric drugs are

harmful and may be ineffective (Whitaker, 2002 & 2010). Even if the truth falls somewhere in

between all of these theories, I still believe it is crucial that the public becomes aware of the

disputed aspects of psychiatry and the risks associated with uncritically believing the claims of

an industry that funds its own research and whose survival and growth depends on new patents, a

wider target audience, and public buy-in.

From this review of the literature, it can be seen that most theories distinguish psychosis

from "normal" mental states. This occurs despite psychosis having no consistent definition;

nonetheless, among the medical profession, Mad Pride activists, and everything in between, there

appears to be a need to single out certain types of thought and behaviour. The medical

perspective on schizophrenia and psychosis dominates the information presented to the public,

despite concerns over the validity of the constructs (in particular the term "schizophrenia"),

despite no universal brain abnormalities that are implicated in psychosis, and despite most of the

studies on the effectiveness of antipsychotics being funded by drug companies with a vested

interest in selling their products (Whitaker, 2002 & 2010). Furthermore, the media presents a

picture of people with psychosis as unpredictable and violent based on very few horrific cases

that tend to lack a discussion of the violent individual's life history or social context. This leads

the public to believe that psychosis is by its nature dangerous, frightening, unpredictable, and

permanent. Psychosis and schizophrenia are referred to as "illnesses" or "diseases." However,

even if an exact biological cause of these conditions was determined, it is problematic to refer to

a psychological state as an "illness" because this dismisses major aspects of a person's identity, and invalidates any lived experience, knowledge, narratives and meaning that people make out of their experiences. Alternative theories on psychosis are important because the psychiatric perspective that psychosis is a harmful condition that must be quickly contained, and that schizophrenia is a genetic illness have come to dominate professional discourse on the topic. This is despite methodological flaws in many studies, and conflicting evidence (Whitaker, 2010).

People who experience psychosis often resist the "illness" definition. In mental illness, the subjective experiences tend to have profound personal meaning, and people with psychosis believe that they are experiencing "heroic striving" (Williams, 2012) or have been granted an important task to uncover some important truth about the world. Researchers like Williams (2012) and Harrop and Trower (2003) attempt to show that psychosis is an extreme version of existential concerns that all people face to varying degrees. Williams (2012) suggests that people with psychosis have "profound insights into the human condition" (p. 289) that may become more bizarre and idiosyncratic in part due to the ways in which people with psychosis are isolated and vilified, or because they have no one to guide them through their "journey", while Farber (2012) presents his book as "A bold call for the 'insane' to reclaim their rightful role as prophets of spiritual and cultural transformation." Williams (2012) notes that his intention is not to write a "romanticization of psychosis" (p. 289), which would imply that the psychotic process is never dangerous, but rather to challenge psychiatric opinion that psychosis amounts to sickness and irrationality. I believe that psychosis is considered deviant in part because of the threats it presents to a capitalist and neoliberal world that rejects notions of intersubjectivity and spirituality. Madness may be seen as inherently radical in its resistance to capitalism and professionalism. However, although there is massive mobilization and resistance

to psychiatric violence online and in Mad Pride and recovery communities, there are varying

degrees of agreement that people with "psychic differences" (The Icarus Project, 2013) should

attempt to learn to integrate into the rest of the world and be given workplace accommodations.

Integration certainly offers some benefits, such as less social isolation (unless one chooses to be

isolated) and more financial independence in a capitalist society. Groups like The Icarus Project

recognize that with extreme mental states often comes suffering, depression, and isolation

(2013). If madness was treated as an extreme type of awareness, creativity or sensitivity that

should be appreciated, I believe that the subsequent social inclusion of people with psychosis

would reduce their suffering overall.

Treatment of psychosis is considered successful when the individual returns to a level of

functioning that involves living a relatively "normal" life, including employment, social

relationships, and a general acceptance of consensus reality. The illness is considered to be

treated, therefore, when their thoughts and behaviour are adequately conforming. The meaning

that the experience of psychosis had for the individual, and the social contexts that shaped their

perspectives, are considered to be signs of "illness." It seems understandable to me that people

with psychosis who consider their beliefs to be true and valuable may attribute sinister motives

to authority figures and family members alike who attempt to suppress them, either through

forced hospitalization, criminalization, or medicalization, and this may earn these people with

psychosis the label of "paranoid" from people who believe they are trying to "help." Psychotic

experiences mean one thing to the medical community and something entirely different for those

living with the experiences, and this leads to the domination and silencing of people

experiencing psychosis. This silencing is conveniently justified by an attack on the credibility of

people with psychosis. Since they are said to suffer from a "brain disease" that prevents them

from distinguishing reality, and since one component of this brain disease makes them unable to recognize that they are sick, their insights cannot be trusted.

Relevance for Social Work in the Support of Individuals with Psychosis

Throughout my social work studies, I have been trained to be critical of the profession. This involves recognizing the extent of social control and oppression that social workers have enacted in the name of 'helping'. Social workers are under increasing pressure to act as agents of a neoliberal, capitalist and individualistic state, surveilling and governing the actions of their clients. However, the postmodern influence on my social work schooling has taught me about the subjective, socially constructed nature of reality, which social workers are obligated to recognize in order not to perpetuate racism, Eurocentrism, and other forms of oppression through exerting their "professional knowledge". Therefore the labelling of particular members of society as mentally ill and therefore as unreliable narrators of their own experience amounts to professional violence. In this paper I have cited some research on the fact that the beliefs that are considered to be psychotic can become a large aspect of a person's identity. By labelling these parts of a person as signs of sickness, I would like to know if mental health professionals may be creating the objectification, alienation from oneself, and "deadened life" that Morgan (2010) proposes is a major component of schizophrenia. Spelman (1978) calls for treating "persons as persons," not in a human rights sense but in viewing someone as "the person whom someone takes himself or herself to be…. We treat others as the persons they are just insofar as we try to respond to the way in which they choose to be seen, and not through our favored ways of perceiving them. Treating persons as the persons they are is trying to see them as they see themselves" (p. 151). Spelman (1978) notes that one does not need to agree with a person's self-conception, or never challenge the person, but one must respond to the person's self-conception,

instead of to details that are irrelevant to the person. If a person with psychosis cares about certain aspects of themselves, even "delusional" ones, the social worker treats the person as a person only inasmuch as the social worker acknowledges this person's self-concept.

Through my review of the literature, my goal was to provide some evidence not only that a purely psychiatric model of psychosis is suspect, but that psychosis as a phenomenon may be shaped by the external social world. If this is the case, then the problem should not be viewed as residing within the individual, but in the social structures that prevent inclusion and integration of all people. It is worth studying which "treatments" not only make the person have fewer psychotic symptoms, but also which ones reduce suffering. The experience of psychosis can be frightening and can cause great suffering for the individual, as well as for family and friends, who may fear their loved one or grieve the 'loss' of the person's previous personality and future direction (despite the fact that people who experience psychosis may "recover" and reintegrate fully into mainstream society). Yet social workers and other professionals should determine, on a case by case basis, where the suffering is occurring and why. Family members may suffer from financial concerns related to supporting an individual with psychosis, but they may also "suffer" because the individual with psychosis holds unsettling views of the world and holds an unacceptable self-concept that family members refuse to acknowledge. Harrop and Trower (2003), however, find evidence in their interviews that when significant others reject a person's presented self, this may actually contribute to psychosis. Farber (2012) cites R. D. Laing, who believed that the suffering of psychosis is caused not by the process of journeying into another realm of consciousness, but by being unsupported in this process. Psychosis may, according to many theories, serve a beneficial or healing purpose to the individual, and it should not be automatically problematized; instead the individual should be guided in their journey (Williams,

2012). Harrop and Trower (2003) note that hallucinated voices can be comforting and should

not be problematized and "treated" without first seeking to understand them and socially include

the voice hearer. Buck et al. (2012) report that people who come to believe they are "ill" mourn

the loss of their "delusions," in which they were important and their lives meaningful.

Eliminating psychotic symptoms without addressing the social context in which they occur may

eliminate the only defense or resistance that the person with psychosis may have. Furthermore,

if people "recover" but are still socially isolated, poor, homeless, or lacking in meaningful

opportunities, how is this reducing their suffering? People experiencing psychosis often resist

being labelled ill or treated with drugs, and social workers need to acknowledge interpretations

of this resistance other than that the individual lacks "insight" about being sick. Social workers

need to be critical of "treating" psychosis without first looking at the possibility that the

psychosis developed in response to injustices and violence in a particular society.

On the other hand, social workers will cause harm if they *assume* that the family is to

blame for the development of psychosis. Social stress, abuse, and other factors have been linked

to psychosis (Read, Seymour, & Mosher, 2004), but it would be harmful to assume that family or

friends contributed to the development of psychosis when in many cases they could be protecting

the individual from experiencing more severe suffering. At the same time, the possibility of

social stressors contributing to psychosis is supported by evidence and by the testimonies of

some people who have experienced psychosis. Medicine has moved away from the mother

blame and the concept of "schizophrenogenic" mothers who were once theorized to cause mental

illness. Without a doubt, it is highly problematic and unethical to place blame and responsibility

upon the mother when children (and mothers) interact with many people and exist in a social

context. However, the medical discourse now avoids practically any discussion of the ways in

which the social environment, traumatic experiences, and isolation could contribute. Even if the development of psychosis is sometimes related to family life, social workers must not blame anyone specifically. Even in cases where a person with psychosis grew up in a violent home environment, this home environment was likely perpetuated by many factors, such as stress related to poverty, racism, immigration, and trauma that the parents may have experienced.

Deegan (1995) notes that psychiatric drugs are just one of many recovery tools, and individuals should have the right to "learn non-drug coping skills that control or eliminate distressing symptoms" (p. 1). When professionals insist that people experiencing psychosis take drugs, this is in spite of evidence of drug-free recovery. Deegan (1995) argues that it is also paternalistic, denying individuals the right to "assume the dignity of risk" (p. 1). Deegan argues that professionals can support the self-determination of individuals with psychosis by refusing to encourage compliance, and by not telling individuals that "they will have to remain on medications for the rest of their lives" (p. 1). People with psychosis should be encouraged to question their medications, their efficacy, their safety, their addictive potential, their long-term effects, and whether they are really needed. Finally, Deegan (1995) argues that professionals should not encourage individuals to be entirely self-reliant and independent, instead encouraging them to utilize supports in an ongoing way. In the sense that we are all interdependent to some degree, I believe that this should apply to all people, not just those with psychosis.

Chapter Five: Conclusion

Through my review of the literature and from my own subjective experiences, "mental illness" is found not to be clearly demarcated from normalcy, nor can it be explained by individualistic, biological definitions as though it exists in a vacuum. I have found that much of the literature challenges the psychiatric monopoly on knowledge, and offers alternate

explanations of madness, some of which view psychosis as transformative, beneficial, or as a legitimate way of being in the world. I recommend that people with psychosis be granted space to present their own interpretations of their experiences, and they be given the opportunity to learn about the deficits and unanswered questions of psychiatric models and to learn about the evidence for other models. Overall, I believe that psychosis is not yet understood on a human level, and it should not be defined purely as a medical condition, because this causes major portions of a person's identity and worldview to be dismissed as evidence of illness. It is not inconsequential to determine if psychosis could be a spiritual or existential phenomenon, and the most biologically determinist social workers, psychiatrists, and other professionals nonetheless still need to be careful to avoid suppressing or delegitimizing other ways of knowing.

Societal discrimination against people with psychosis is extreme. The media will make a point of noting experiences wherein people who commit violent acts also had a diagnosis of schizophrenia. Little is ever mentioned of the violence inflicted against people with psychosis. This violence takes many forms: forced hospitalization, damaging drugs, eugenics, police violence—but this paper focused on the violence of psychiatry in its systematic silencing and delegitimization of the perspectives of people who experience psychosis by labelling them as ill. For social workers and medical professionals, people with psychosis are to be reformed, treated, "recovered," and if not, they may be institutionalized. Yet there is little acknowledgement that psychosis, from a phenomenological position, evidently arises in individuals who are aware on some level of the social construction of reality, and who experience doubt and suspicion over aspects of the world that are often taken for granted.

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