Seeing the non-psychosis that we share

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A man should not strive to eliminate his complexes but to get into accord with them: they are legitimately what directs his conduct in the world

- Sigmund Freud

For purposes of clarity and to honour human beings that have shared in growth through mutual acceptance and being in accord with one another's individual and shared realities, we will begin by introducing you to the Community that sparked the concepts within this paper.

The Community of (non) psychotic people – circa 1998

Eight individuals shared a residence on the edge of a town a short distance from London. It could be said that we were 'between' social structures. Although society had a structure to define the group – psychiatric diagnosis – the sense of being between the cracks of society's structures was obvious. We were neither hospitalised acutely psychotic individuals, nor recognised as full citizens of the community in which we resided. The community

within the house was a place where a form of equality existed by default. Our shared sense of alternative realities brought interconnectedness within the community, but also created separation between us and the wider community. Amongst our community, we accepted the realities, or at least did not seek to change the experience of the other. It was at these points of interrelatedness that the psychotic realities evaporated. The human to human phenomena allowed individuals the opportunity not to be experienced by others as psychotic: This phenomenon demonstrated a paradox to traditional views on psychosis. The community provided a new structure that became the reality in providing interconnectedness of the human relationship as a new co-existing shared experience. The process was often experienced and enacted between the souls living in the housing community.

Introduction

When human connectedness is fostered with a person who is experiencing extreme states such as a psychotic reality, the recognition of their 'being' facilitates potential for developing a shared social connectedness. This paper will use the concept of the liminal space to explore how the human to human relationship (Travelbee, 1972) facilitates growth between the person said to be experiencing psychosis and the person with whom they relate. Growth will occur within a loving, non-goal orientated relationship. When a person listens, without agenda, in relationship with another, who is experiencing a psychotic state, it will inevitably lead to the emergence of the non-psychotic state. The interconnectedness facilitates an existential

experience which negates the need for an altered state to defend the threat of nihilation (reduce to nothing) in response to ontological insecurity.

Michael Jackson states that the existential imperative is crucial to the human psyche in that people need to tell others that they exist, otherwise they disappear into existential oblivion. Secondly, any psychological crisis needs to be quickly addressed. The psyche cannot be in a non-equilibrium state for too long. Ontological security needs to be retrieved. (Arthurs – needs a reference)

In the 1960's Laing (1960) articulated the emerging and evolving intensity of ontological insecurity that can lead to altered states and ultimately a person experiencing nihilism within the psychotic state. Furthermore, non-medication environments can provide healing to individuals labelled as psychotic and in acute distress (Mosher, Hendrix & Fort 2004). Recent authors including Romme et al (2009), Corstens and Longden (2013) have demonstrated that personal meaning can be found in understanding alternative realities in relation to the events in a person's life.

The basis of the paper suggests that 'right understanding', understanding of the person's reality, is the process by which any listener can 'meet' the psychotic person in their state of reality. In Buddhist philosophy, 'right understanding' is a state of accepting the reality of 'what is', understanding without intention to change, without a goal and with acceptance that the moment will, by the law of nature, change (Arjahn Sumedho, 2012). The listener's action of right understanding facilitates the person being able to observe a non - psychotic state. This theory is consistent with Rogers (1967) description of a 'very paradoxical thing'.

Rogers (1967 p.22) highlights:

"Yet the very paradoxical aspect of my experience is that the more I am simply willing to be myself, in all the complexity of life and the more I am willing to understand and accept the realities in myself and in the other person, the more change seems to be stirred up. It is a very paradoxical thing- that the degree that each of one of us is willing to be himself, then he (sic?) finds not only himself changing; but he finds that other people to whom he relates are also changing. At least this is the very vivid part of my experience, and one of the deepest things I think I have learned in my personal and professional life".

The case of Maddie will further illustrate the paradox that exists when individuals are willing to be themselves in relation to another in the context of extreme states and the potential for change and growth. Maddie resided in the Community previously mentioned.

The case of Maddie

Maddie would arrive in a shared space in the house and ask for the machine to be 'turned on'. The 'machine' was in the middle of her back, a place that she could not quite reach. Any one of the community members might turn the machine 'on' and this would have a significant impact. The television would then tell Maddie that she was the cat murder. Maddie would then express the experience of her sister being angry at her for burying the rat in the garden. When this occurred, Maddie would ask any member of the community to turn the machine off: a request that was duly obliged as part of the co-existing same experience when members of the community

experienced the alternative reality as not being defined different, extreme or unusual to the 'community' in which they resided. Maddie would then cease to be considered to exist in a manner that would constitute a psychotic person. Perhaps this was the moment when psychosis was not needed to keep her safe from nihilation. Considering these types of interaction and human relatedness through the psychiatric lens, the housemate may have been considered to be colluding in the delusion – the likely labelling in a psychiatric setting.

Within the community, the equality of a rudimentary structure of humane relatedness, as part of the ritual of liminality, might have begun the process of ceasing to submit to psychosis as the notional 'authority'. This example demonstrates something of the potential for psychosis to be present for a reason (vulnerability in existence), and conversely psychosis not to require an imposed response, when the human to human dynamic allowed the person to remain safe. In essence, the sense of co-existing same experience was enacted towards a goalless interconnectedness of the people encountering one another.

Conceptual Framework

Listening to an individual with compassion and without goals, supports an individual with an alternative reality such as psychosis, to experience a non-psychotic state. The importance of the listener holding the space of non-intention provides recognition of the person as a 'being' that can exist as part of human interconnectedness. This relational dynamic allows psychosis not to exist and facilitates the individual rebuilding their sense

of being, safety and identity; thus, the individual has an experience of reclaiming their sense of self from the liminal space.

Turner 1969, described “threshold people” or liminal personae. These are individuals who elude classification and who are neither “here nor there”, they are “betwixt and between”. They are temporarily stripped of worldly status and privilege. Liminal spaces, however, are ambiguous and creative. Liminality provides a space of empowerment for the individual. Liminality offers a space for transformation and healing. In the therapeutic space being expressed in this paper, both individuals in the relationship could be considered to have developed something of a communitas, a contributor to the emergence of the non-psychotic experience and cessation of threat to nihilation.

Despite the many conceptualisations of alternative realities that many individuals experience as meaningful, the traditional and dominant psychiatric paradigm continues to label and seek cure through diagnosis and pharmacological treatment frameworks. This lens is owned and purveyed by clinicians, not individuals who experience alternative realities. Therefore, minimal emphasis is placed on the individual’s meaning: the individual who is experiencing an altered state of reality. The process of considering meaning in response to the dominant discourse often pushes individuals into liminal spaces outside of mutually defined frameworks towards isolation and nihilism, as the potential to exist in relation to others diminishes.

There is potential for therapists to thwart the opportunity for an individual to experience a person witnessing rather than disputing or seeking to

change their meaningful reality in a shared experience (Arnold, K., & Vakhrusheva, J., 2016). In this process the therapist denies or seeks to change the person's perceptual reality. This is the antithesis of the co - existing shared experience: two individuals connecting and finding safety and security in their mutual acceptance and right understanding of their expressed individual and shared realities. The following metaphor provides an example of the compassionate non - intentional space as being legitimate in removing the need for a psychotic response to fear, which may affect both individuals without right understanding and awareness.

The bird in the roof – a metaphor

I had a bird trapped in my roof. I could hear it flying around. It kept bashing into the walls trying to be free from being trapped. It appeared quite 'psychotic' – not accepting the (my) objective reality that it could not find an exit. I wanted to help the bird and after several attempts to 'catch' the bird to free it from the roof space I sat down and waited. I thought I was just waiting, but after 2 hours when the bird sat on my leg, almost within touching distance, I suddenly reached out and tried to grab the bird. Previously unaware, I discovered I was not just sitting 'with' the bird: I had a strong intention – a goal. I was seeking to change the bird's reality to a reality that allowed comfort and integration of the experience for me – I wanted to save the bird.

The bird acted on fear and flew away from me significantly faster than I could move towards capturing it. The bird again began to fly around 'psychotically'. I then sat for another 3 hours before I could reassure the

bird that I did not intend to capture it – the bird had facilitated me understanding that I previously intended to do just that. After 3 hours, the bird hopped up my leg again and eventually sat on my hand. At this point I was able to gently bring my hand around the bird, nurturing it as I exited the roof space, setting the bird free.

What did I learn? If my intention was to take action that the bird inherently felt threatened by, it would not come near me, displaying agitation as a response to the threat. When I allowed the bird to take control and move to a space where I could help it feel safe, we shared an experience – to feel free: the bird not trapped and I not feeling distressed by a trapped bird. Just as the bird manically flies trying to maintain its safety when trapped, so the psychotic person will always be experienced as psychotic when the person witnessing attempts to 'treat' the meaningful reality of a sense of being trapped. Only when my intention was removed could the bird safely return and the needs of both were shared and accepted and an accordance with each reality achieved.

The compassionate non-intentional space described above is echoed in the interrelating of individuals seeking to make sense of psychotic reality when sharing a liminal experience.

Discussion

Despite traditional psychiatry's notion that delusions are fixed, false beliefs impervious to challenge, in fact many individuals have doubts about their delusions and as opposed to being fixed, their convictions and the strength of their delusions fluctuate over time (Arnold, K., & Vakhrusheva, J. 2016).

A person who is distressed and deemed, by another, to be psychotic often appears unable to rationalise and engage in a way others can understand. But what if alternative states, psychotic or dissociative, are ways of being, not primarily out of control, dangerous, concerning to safety, but in the context of ontological insecurity and a fear of being nihilated, legitimate ways of being?

In the clinical setting, if we cease to have goals, objectives, intentions and needs for outcomes and instead, value the sharing of the two realities of the individuals in the therapeutic encounter, over time, the psychotic or dissociative person will at some point not require the altered state to make the (inter)relationship safe. This phenomenon highlights that once the person in an altered state of reality experiences the other as not seeking to change his or her state, but to be in accord with the relationship between the two people, the alternative reality can become experienced as legitimate and acceptable. Being in accord with one another's individual reality and the experience of each other, offers the potential for the psychotic or alternative reality state to subside as the safe ontological experience emerges.

In other words, the subsiding of psychotic or alternative reality occurs through the process of both individuals sharing a safe space of 'non psychosis'. The individual no longer needs to defend their existence by unconsciously producing an alternative reality. When both parties become aware of the co-existing same experience of safety, the so called psychotic person has experienced a new reality in the relationship with another. This

experience of safety can form the basis of the person moving away from the fear of becoming nihilated.

As safety and feeling of security emerges in the persons conscious, so the non-psychotic experience can continue to be explored and experienced by the individual both within the self and within relationship. The following story of Mick will demonstrate this process.

The clinical world

Mick was in an acute hospital as an in voluntary consumer, having been placed in a secure ward. Upon discussion with a psychiatrist he had expressed that the voices were telling him to kill people in the ward, including the psychiatrist and the nurses. Mick verbalising this content of voices to the psychiatrist led to his detention. Prior to the conversation with the psychiatrist, Mick had been openly discussing his voices with the nurse that would later be invited to spend time with Mick, a conversation that had included the same content but had not raised alarm to consider detaining Mick, due to the nurse taking an acceptance and meaning based approach to understanding the voice hearing experience.

During the conversation with the psychiatrist, he was also making various 'threats' (articulating fears) in the direction of other individuals who resided on the ward. A nurse with an interest in spending time with psychosis as a way of allowing it to appear, or not appear, as is the functional need of the individual experiencing psychosis, was invited to speak with Mick. The nurse and Mick were joined by a second nurse who

had an equal interest in facilitating a person to 'be' in their experience, rather than seeking a target or goal of the interaction.

When the process of the therapeutic encounter unfolded, Mick began to describe the phenomena. As Mick articulated the range of voices, visions and auras he was experiencing, he referred to the voice directing him to kill the nurse that was relating with him. Mick was sitting in a relaxed posture, on a comfortable chair and was facing the nurse. The nurse was not experiencing any sense of threat, but was interested to understand more about Mick's experience. The nurse articulated his sense of feeling safe despite the voices given directions to Mick. Two significant considerations were made by the nurse and explicitly explored with Mick. This was not a planned 'intervention', simply it was the internal consideration of the nurse who sought to understand more of Mick's realities towards a co-existing shared experience. 1. Do you (Mick) want to kill me? 2. What does it feel like to hear a voice stating you should want to kill someone, when you do not want to hurt that person?

Mick was clear in stating that he did not wish, or intend to, kill the nurse, despite hearing a voice expressing views to the contrary. He immediately became distressed and upset at the sadness that the nurse might think Mick would want to harm him. He began to weep. He expressed that he felt guilt and shame in hearing a voice instructing him to kill the nurse who was demonstrating safety and care towards him. In this example, Mick's response demonstrated his ability to manage his fears in the interrelationship and did not need to maintain psychosis.

The nurse was not seeking to change any aspect of a psychotic phenomena, nor did he intentionally use 'skills' or 'strategies' to help Mick change a reality. The nurse's response was to offer himself as a listener and witness, with 'right understanding' of Mick's realities, and to invite Mick to be himself in that moment. The minimal sense of externally projected responsibility from the nurse facilitated the sharing of the experience of one another. The observation from both individuals, having accepted the respective invitation, was the natural development of a bridge: a place across which the two individuals could travel to find a shared experience within the interrelationship. In doing so the experience facilitated movement from the distressing and disabling sense of being psychotic towards sharing a loving and accepting space.

The nurse asked Mick what he hoped could happen next. After a pause, during which the tears and emotions of Mick were clear, the nurse enquired as to whether Mick would value a hug. Mick stood up, cried more overtly and then embraced the nurse. Sometime later Mick and the nurse reflected on the connection within the human to human relationship. Both Mick and the nurse identified the lack of psychotic phenomena in that moment of connectedness.

The non-psychotic experience became a river through which the transition might flow towards deeper interconnectedness, meaning and safety, with an inevitable emergence of non-psychosis. A ritual could be operationalised and the process of emergence from liminality could begin. An interconnection had been sparked and the so called psychotic state ceased to be a barrier. Mick walked outside of the social (non) structures

of being psychotic, towards more readily embracing a co-existing same experience with the nurse.

Considerations

In conclusion, these scenarios require the following considerations in order to integrate concepts into action when a person is to facilitate the role of listener, as the person with an altered state emerges towards safety and security of 'being'. Firstly, the label of psychosis is not of value because it implies that it is a disease state that needs treatment, especially to make the other (non - psychotic person) feel safe. This creates a 'goal' and thus does not allow the very experience of safety of 'being' that we have suggested underlies the need for the altered state labelled as psychosis.

As a priority there is a need for a paradigm shift that sees an alternative reality as a primary function to resist nihilation, rather than being classified as an illness. This allows us not to have 'goals' or consider 'treatment' and allows the person to be seen as functionally responding to unconscious threat of nihilation. It places the psychotic person as having the same basic human insecurity that is shared and navigated by all beings.

Secondly, the psychotic and non - psychotic person share the same primary insecurities in the form of fear and the need for safety and protection against nihilation. Traditionally, within the therapeutic encounter the 'psychotic' person is not safe therefore the clinician seeks to divert their sense of vulnerability in changing the psychotic reality. This process of denial contributes to the person's experience of nihilation.

The psychotic person may be in a state of feeling unsafe due to the actions or 'being' in relation to another person. As the individual cannot change the fact of another person existing, they change their own state (unconsciously), the energy of this state serves to stave off complete nihilation of their existence and soul, but does leave them in a liminal space in the world. At this point the psychosis can become exacerbated as the individual navigates the liminal space of existence and non - existence. As with all people, the psychotic person is not born psychotic so, at some level they experience their own sense of sanity and a semblance of security in 'being', but cannot feel it available or present at that time in relations to other beings and begin to fall outside of societies norms as a consequence. Finally, the goal simply becomes being able to experience ontological insecurity, without experiencing the threat of being nihilated and without seeking to 'change' the experience of the other, but to get into accord with one another. This is the co-existing shared experience. For this to happen we have experienced the fear of nihilation as the other person experiences the same. This representation of the process as an extreme state is often defined as psychotic, with significant potential for harm and negation of the potential for growth of the meaningful reality for both individuals.

Conclusion

Accepting the vulnerability of the co-existing shared experience is an experience of the same threat to both the psychotic and non-psychotic person. However, accepting and simply 'being' in the relationship can facilitate each of the individuals to create the opportunity to self-define and

self-determine a new perception of the reality of the shared insecurity and vulnerability. It is within moments of co-existing shared experience that the psychotic person can experience non-psychosis, and the other person can experience a genuine acceptance of the other person's rational state, not as a psychotic disorder, but a unique and functional response to the often unspoken, unacknowledged co existing shared vulnerability of all beings. The place of acceptance offers a glimpse of a 'non-psychotic' persons own potential alternative reality – managing a sense of being in a liminal space.

Traditionally, the person seen as in a non- psychotic state finds genuine acceptance of the alternative reality of the other as meaningful and potentially of value. The ultimate shared reality for the non-psychotic person is the risk of being considered to be in a potentially psychotic state by peers, systems and society. This occurs simply by taking the position of a shared experience and acceptance of the person labelled as psychotic not as having an illness, but as a response to a common shared reality: that of vulnerability and fear, especially in interconnected human relationship.

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