Chapter 1

Treatment or Therapy?

The medical model of handling the acute “psychotic” episode comes under the classification of what is known as “treatment,” which implies doing something to the patients to relieve them of their symptoms, even if not to cure them. The alternative paradigm I am proposing is based on a concept of a “therapy” that gives respectful heed to the psychic process underlying the symptoms. The original meaning of the Greek word therapeia was a “waiting upon” or “a service done” to the gods, with implications of tending, nurturing, caring, and being an attendant; in time the word was applied to medical care.1 The original connotation is pertinent to the handling of acute “psychotic” episodes, since the persons undergoing them are in a state of being overwhelmed by images of gods and other mythic elements. Hence a therapist does well to “be an attendant” (therapeutes) upon these mythic images so as to foster their work. “Treatment” strives to stop what is happening, while “therapy” attempts to move with the underlying process and help achieve the creative aim implicit in it.

To propose a therapy of this kind in the psychiatric field evokes quite a negative response since it collides with a number of assumptions held in the medical frame of mind. My effort here will be to point out and outline several habits of thought that govern this profession’s approach and methodology.

The most prominent of these is the inordinate fear and mistrust of disorder itself. The general consensus holds that the most immediate task is to repair the various mental disorders as rapidly as possible after diagnosis. During routine hospitalization, the staff on the hospital unit become highly upset at disordered behavior and make quick decisions to suppress it, and they feel distinctly reassured when order is maintained and the milieu becomes quiet with the return of normalcy. This behavior may seem perfectly natural and plausible, but an unfortunate consequence of this attitude is that a disintegrative phase of what may be regarded as a developmental process becomes disqualified and ruled out.
Under the alternative model I am proposing, turbulence can be regarded as natural rather than disastrous. Contrary to our general expectations, growth and development do not proceed in a linear and upward fashion, smoothly advancing from point to point like grades in a school, however much we might wish for that. Rather, growth proceeds in a cyclic fashion, with alternating periods of calm and turbulence, progression and regression. Every few years there is an upset in one’s experience of the world and a fresh start on a new footing begins. The acute episode we are considering here is another one of these highly charged upsets, but, of course, much more radical in the mode of change and more deeply disturbing. Perhaps only a little less radical than the acute episode is the phenomenon formerly known as “the adolescent storm”; the young person experiencing this state is more usually assessed as a “crazy, mixed-up kid” and the accompanying behavior has remained somewhat allowable, perhaps because “it’s just a phase.”

The customary imperative to quell turbulence and disorder, as something to repair without delay, is comparable to the way our culture has regarded death. We have viewed death as something to be defeated at all costs and our fear of death has much the same quality as our fear of chaos and disorder, and prompts a similar response. All kinds of inordinate medical technology is brought to bear on the body to keep it alive, even when nature wants to close the book, when it is time for the body to let go of the soul and leave it free to get on to the next thing. But our medical profession is dedicated to fighting death as a dark and dread enemy, just as the psychiatric profession is equally dedicated to overcoming disorder as a similar and fearsome foe.

Now, turmoil and disorder are anything but disastrous if we can actually look into the process giving rise to them. If we listen to the individuals in the episode in an empathetic and caring manner, without the need to manipulate, control, or make them be quieter or different in some way, we find, much to our surprise, that they may change spontaneously in a quite short period of time. We have only to sit and relate openly with persons in the episode to find that what had once been a fragmented state of scattered associations, may now begin to assume a coherent form with clarity of thought. Setting up in this way a bi-personal field of relationship, that is, one in which two psyches are in a process of opening up to each other, may establish an organizing effect that stimulates an integrative process. Fear of disorder or turbulence negates this desirable state, while a sense of open receptivity encourages it.

When we admit individuals who are at the very onset of their acute episode and at the height of their disordered state, they may be fragmented, often mute, with scattered bits of ideation passing across the
mental stage. At this phase of the process the mental content is a hodge-podge and the ego has quit the field, lost in the deep interiors of the psyche. Listening to an individual at this time gives kaleidoscopic glimpses of mythic themes that often leave the listener bewildered. Yet if we sit quietly and attentively with a person in this state for only two or three times, we may find the fragments coalescing into a story that gradually begins to move forward. This development, it is important to add, is true of most cases, but not all of them.

The initial disordered state that I am describing contains two distinct elements. The first is an experience of dying or of having already died, which symbolizes a dissolution of the accustomed self. The second element, closely related to the first, is a vision of the death of the world. These "world-destruction fantasies" involve the dissolution of the person's world-image, which symbolizes the accustomed culture or sub-culture by which the psyche has organized its experience of the world.

Studies of rapid culture change show that the visionary experiences of prophets frequently contain images of the world disintegrating and being reabsorbed into chaos, which then allows a regeneration to occur. In these accounts it is clear that what is being transformed is the image of the culture. We also see this process in the acute episode; one suffers the collapse of one's accustomed cultural models. One's basic security and long-held value system, as well as one's view of the world, are shaken up and disassembled, preparing the way for their reconstruction. Meanwhile, the psyche remains in a state of inchoate potential. This process, however, is autonomous and moves naturally into the reintegrative phase.

A therapist does not have to provide the initiative to move this sequence forward or make it be something other than it is. Even our therapeutic interpretations can be minimal, such as simply a lighting up of the eyes to indicate an acknowledgment and recognition of the import of the images. The expression of interest has the effect, in itself, of encouraging the process to move ahead.

Seen in this light, our fearsome "disorder" is merely nature's way of dismantling what was inadequate in the past, and in so doing allowing a new start. We would do well to let nature and the psyche do their work in their own tumultuous way. (Some encouragement for this attitude is found in the recent recognition of the role of perturbations in processes of self-organizing systems, as explicated in the works of Jantsch, Prigogine, and Gleik.)

The second habit of thought prevailing in the mental health field to which I wish to draw attention is one born of the unfortunate marriage of psychiatry to the notion of brain disorder as being the prime cause of
"psychotic" episodes—an unfortunate love affair that we hope will be a passing one. Researchers in their various fields who take this view often feel called upon to make a number of expert pronouncements to the effect that we should simply disregard the psychodynamics and psychotherapy that formerly used to draw so much attention, because in their opinion, such approaches have nothing to do with psychosis. In their view, it is to the brain disorder that we must now give our attention.

This perspective presents a most discouraging picture of the future for the individual in the psychotic state, since it suggests that the brain is somehow faulty and will remain forever different from others. Any such judgment can cause severe alienation and stands in need of correction. That frame of thought is based on a mechanistic-causalistic model implicit in biomedical reductionism and represents a philosophic fallacy characteristic of Western thought. Such a model considers anything physical or chemical to be a more fundamental cause than other factors in that it is viewed as being more substantially "real."

In the old language the mind is considered to be a mere epiphenomenon of brain activity and is seen as therefore less real, not lending itself to objective investigation or scientific scrutiny. The psyche's activity is seen thus as quite secondary to the supposedly more basic play of changes at the physical and biochemical levels. Even as late as the 1930s, it was still difficult for our profession to accept the premise of psychosomatic medicine, asserting that the psyche's problems and disturbances could produce effects in the internal organs of the body. A little later this formulation was accepted, but only for certain syndromes such as ulcers, hypertension, and asthma, which were considered to be exceptions to the general premise that etiology was primarily the province of biochemistry and physiology.

Reductionistic assumptions such as these overlook the obvious observation that the parts of the organism move together as a whole. Psyche and soma, with their attendant emotions, physiology, anatomy, and chemistry all operate simultaneously in coordination with each other and the whole. To say that the part is prior to the whole, in a causative sense, is to lose any sense of the wholeness of the organism. This is especially true in regard to the emotions. In rage, fear, love, or grief, the physiology changes in ways specific to each, yet one cannot therefore say that the anger or grief reaction is caused by the chemistry! The reality is simply that the biochemical processes participate in the total experience of each emotional state. The biochemistry is not a cause but a concomitant. If this is so in regard to ordinary emotional states, it must especially be the case in turmoils as severe as acute psychosis. (Engel has made an eloquent appeal for recognition of the need for a
new mode of conceptualizing that embraces all levels of experience of
the organism, recommending his biopsychosocial model.4

The question of a genetic factor in the formation of the brain that
produces a proclivity to psychosis is also part of this same issue of
causation. Some current researchers hold to the idea that the effect of the
gene currently under scrutiny is one that conveys an inclination toward
extrasensitivity as opposed to pathology; if this is so, it would fit the
psychological observations much better. The individuals most apt to
undergo an episode of the kind we are examining are usually endowed
with a highly sensitive makeup, so that in childhood they were inclined
to perceive falseness, defensiveness, and hidden emotions more than
others. The perception of such characteristics is usually, of course, less
than welcome in a family accustomed to denial. These sensitive indi-
viduals accordingly were made to feel in an awkward position because
they perceived what others did not and hence they were made to feel
odd or wrongheaded, resulting in a sense of being excluded from the
oneness of the family circle and cast in the role of the family scapegoat.
These and other points have been extensively pursued and documented
very tellingly in the work of Laing and Esterson in Sanity, Madness and
the Family.5

The best evidence for the proposition that the “psychotic” state
cannot rest upon faulty anatomy, physiology, or brain chemistry is the
readiness for the syndrome to clear up even during a single interview, at
least for a time. One may sit with a person enveloped in the psychotic
state and reach a point of good rapport, allowing an open connection to
be reached in the relationship between the two persons involved, and
also between the individual and the underlying psychic process. In such
conditions the psychotic state may abruptly clear up. There can occur,
then and there, a return to coherency and clarity of thought, and the so-
called “thought disorder” can melt away. This change may last for a few
hours or even a few days and then the individual may slip back into his
or her former psychotic mode, or the coherent state might, with good
fortune, persist. After such experiences as these it is increasingly difficult
to conceive of a brain or biochemical disorder as being the primary
causative agent of such states. A further corroboration of this point is the
occurrence of rapid change from a psychotic condition in clients in only
one to three days. This change occurs very frequently with no medica-
tion needed to bring this about, when the setting is favorable.

A third habit of thought in the psychiatric profession I would like
to cite involves an issue quite close to those previously discussed: it con-
cerns the nature and role of emotion, a subject that has been fraught with
controversy since the beginnings of psychology. Since the late nineteenth
century emotion has been considered a "disorganizational response," a view borne out by such tests as the recording of hand tremors before an ordeal such as an examination, demonstrating on a graph that emotions interfered with normative functioning. An informative review of the history of such unfavorable attitudes toward emotion in academic psychology has been written by Leeper. In the cognitive therapy school of Ellis and others' emotion is regarded as an unnecessary mode of behavior that is best examined with rational criticism rather than being expressed. The same attitude is prevalent among those treating psychosis. Emotions are viewed as constantly threatening to be out of hand and when they are stirred up matters are handled rigorously to prevent disturbance. There results an inclination to keep the emotions suppressed in order to maintain an atmosphere of calm and quiet as well as a general sense of order among the patient community and hospital staff.

The episodes under consideration here come under the diagnostic category of "thought disorder," implying a tendency toward concreteness of thought and impaired ability to abstract. However, we find in therapeutic work that the more fundamental problem is an impairment of the affect, which is often found to be flat, blunted, or at least inappropriate. As soon, though, as we can establish a good therapeutic relationship with an individual in a psychotic state, we find that the affect begins to act more naturally. Indeed, part of the healing process consists of getting the affect to move and be more vivid.

In the "high arousal state" that is, when the deep psyche is highly activated in the "psychotic" episode, the colorful mythic images are representations of core emotional issues. In the normative state, images are part of the nature of emotion and consequently image and affect operate hand in hand with each other. An image renders the meaning of an emotion, and the emotion gives the image its dynamic. In the "extreme altered states" (in the acute "psychoses"), this connection tends to fall asunder, producing one of the foremost "splittings" formulated by Bleuler and causing him to name the syndrome "schizophrenia" ("splitting of the mind"). A result of this "splitting" is the phenomenon of images floating through the field of awareness without coherent connection to the emotions that would in the normative state naturally belong to them. An example of this would be a person speaking of the collapse of the familiar world as if it were no more alarming than saying that the market will be closed tomorrow. In this fashion frightening and utterly horrendous world and cosmic events are portrayed without fear, and in listening we are left with an almost inanimate picture of them. Emotional expression is designed for communication and therefore, in
the therapeutic model I am proposing, it is the communication in the therapeutic relationship that allows the affect to be restored to the image.

This restoration is particularly desirable in regard to the more problematic emotions and the conflicts associated with them, the angry and sexual ones being the two of greatest concern. These emotions frighten staff members in hospital settings more than any other and call for the greatest degree of suppression in the name of law and order, yet these are the emotions most needed for the future growth and development of the personality.

Anger is essentially the raw, root material out of which evolves an assertiveness most needed by a weakened ego, and sexual emotions are the ground out of which evolves a capacity for an intimate and caring relatedness to others. This sense of bonding is vital for those individuals who have typically evaded closeness because of the fear of being hurt. The acute episode aims to liberate both these affects and yet the law-and-order orientation in our present-day hospital system prevents the very process that nature is attempting.

An example of this may be seen in the case of a resident I once supervised who had charge of a young man who, in giving vent to his rage, started breaking the hospital furniture and had to be confined to his room. The staff were made understandably anxious and became intolerant of his behavior. He was considered unmanageable and the plan was to have him sent on to the state hospital. I advised the resident to sit with him for as long as possible and hear what his anger was about, and thus get to the issue more directly. The man ranted for an hour or two in a long and wearing session, but in this way the underlying issue was actually reached and he was able to quiet down of his own choice. The result was that he remained in the hospital instead of being transferred.

In my experimental projects we have set up a "rage room" as a safe place to let fly with whatever needed to come up into expression. If a client were cutting up excessively and had to work off the anger, we would invite him or her to this place, where the walls were sound-proofed and cushioned, as well as the floor. Cartons and other expendable objects could be beaten up, boffer swords could be swung, and a life-sized punching bag attacked. This room became a favorite place to frequent and had a meaning opposite to that of the conventional "seclusion" room, where someone would be locked alone behind steel doors with only a little window to peer through. In the "rage room" a staff member would accompany the client inside, hear, and even receive the rage, and together they would find the meaning of it. This experience has been very powerful and highly therapeutic.
Issues involving sexual emotions are no less difficult for a hospital staff to handle. We had a young woman client in our residence facility (Diabasis), in her late twenties, who was married, a mother of two, but whose marriage was in difficulty. Our experience with this woman raised a number of problems around sexual issues that represented themselves in her initial identification with what, in her words, she described as the "Love Goddess." She was so constantly seductive with the male staff members that they were made anxious and somewhat intolerant of her behavior.

She came with the conviction that she was dying and that her god was a plant that was withering and dying. She felt herself to be in the Garden of Eden as a little girl. She was solidly identified with what she described as the "Goddess of Love" herself. She saw a "War of the Worlds" threatening the destruction of our world by earthquake, flood, and fire, as an apocalypse that would usher in a "New Era" for mankind with the "Coming of the Lord" from outer space as a new messiah. Her spiritual calling, she knew, was to prepare the world for this great event. The spiritual rebirth arising out of her initial death experience she envisioned as tender green shoots growing out of the withered divine plant, calling them her "new reborn feelings." This line of thought was no mere chatter: she was picturing actual events in her psychic life, namely her awareness of her new capacity for relating to people with more caring. This warm feeling amounted to a differentiation of the potential for lovingness from its archaic state in identification with the "Love Goddess." She was indeed entering a new state of her inner world after abandoning the old one.

Within a month she began perceiving that she was not actually relating or even listening well to other people and thus not allowing them to connect with her. The love she had spoken of was merely an archetypal image of love, personified in the deity and felt only in its cosmic dimension, full of a vast potential but by no means actualized or personalized. Any component of one's development, such as love, first appears in an archetypal form as a potential and motivation for certain functions. The inchoate potential evolves step by step through a number of concrete experiences into a capacity for intimacy and a caring relatedness with others. By the end of a few weeks this young woman's feeling was no longer showing itself as sexual playfulness but rather as real human warmth.

For someone in the acute "psychotic" episode it is essential to go through this differentiation of the Eros principle" and it must not be opposed, inhibited, or stopped. Our staff at Diabasis were selected on the basis of their being caring individuals who would be open with each
other and form an affectionate community, and in this way model for our clients a way of living in relatedness.

The fourth habit of thought that I would like to consider concerns the negation of the existence of an inner life. A large proportion of our profession, as well as others in the mental health field, are heavily influenced by the behaviorist school of psychology as well as one of its major derivatives, behavior modification. Even more are under the sway of the various schools of psychoanalytic thought, some of which still hold to a biologically based framework of drives and their prohibitions, sublimations and vicissitudes, a model in which the unconscious is, in large part, derived from repressions. In such circles the mention of an inner spiritual life, with its own requirements to foster its inner processes, evokes little recognition and is apt to be quietly dismissed as too mystical.

These views of the psyche, postulating that it can have no internal life of its own in depth, no inner world developing by its own quite different modes, represents a philosophic bias that has dominated our thinking about the psyche since the seventeenth century. This view was expressed by John Locke, who stated the proposition that we come into the world with a mind that is a blank slate or "tabula rasa." What we come to be is then the creation of our experience, composed of the input of our senses, thus allowing the conclusion that there is nothing in the mind that has not come through the senses from outside.

One of the most influential expressions of this quite negative view of the deep psyche is Silvano Arieti's Interpretation of Schizophrenia. In this work he portrays schizophrenia as an "escape from reality" through the mechanisms by which the patient attempts to "envision reality in a less frightening manner," that is, when his defenses become increasingly inadequate. These defenses are "mechanisms which were used by the human race in the process of becoming the species that it is today. In other words they are obsolete, archaic mechanisms, buried long ago in unconscious processes." Arieti speaks here of psychiatric conditions in which one finds "the use of less evolved mechanisms for functions which require higher processes. These bring about peculiar situations," he states, "that have never occurred normally in previous stages of phylogenesis." This may reinforce the point that some interpretations are "nothing less than phylogenetic fantasies." He further believes that "it would be nothing more than phantasy to explain phylogenetically the dynamics of a single state of schizophrenia... This is the mistake Jung made. Jung thought the collective unconscious could explain the motivations of the individual. This is not the case." He states that "to understand the formal or psycho-structural aspect of a psychiatric condition..."
we must transcend the ontogenetic level.” In these statements Arieti grants little value to the work of the archaic, myth-styled images in the process of psychic reintegration, which according to his view, must come from a higher structural level better orientated to outer reality. In that model the higher structural level is the synthetic function of the ego as defined by psychoanalytic theory. Yet the integrative process that we have seen is in no way being performed by the ego, which, if anything, remains in a state of disintegration until the process has been completed.

With the bias that there is no inner spiritual life with a purpose of its own, there would be no place for the spontaneous and autonomous inner processes in depth, particularly those of a self-healing nature. Yet it is just those processes that we see in the acute episode so regularly that they appear to be predictable: a sequence of images recurring in case after case, representing the moves of an inner life going on quite independently toward their own goal. If in listening to this process we get in the way, it proceeds regardless and pushes us aside in order to move ahead, and if we are not receptive to certain levels of this development, there is a tacit response, that if verbalized would be: “To hell with you, I'm not going to tell you much!” There then ensues a withdrawal, leaving the listener in a position of never hearing what is taking place in the individual. On the other hand, if our face lights up to what is being communicated, with a sense of recognition of its import, then in doing so we may find a whole wealth of material pouring out that we would have never even guessed was there.

In my view, it is the existence of this inner life, with its own process of reintegration through disintegration (in much the same sense as the process studied by Dabrowski) that provides the principal justification for the regimen of psychotherapy without medication in a residence facility. Naturally, it is more humane to have a homelike setting for handling the acute episode, one not regimented in a law-and-order atmosphere; that quality alone would make it beneficial. Yet of far more importance is the arrangement of an environment in which nature is allowed to proceed with its self-healing processes, designed to give them full acknowledgment and affirmation. If the facility were not aimed at this purpose, the entire concept would be far less convincing.

In addition to Diabasis two projects in the San Francisco Bay Area have demonstrated the advantages of regimens that did not rely on the use of medication: the Agnew Project, which was not residential, but showed the patients doing better without medication by a ratio of nine to one; and Soteria House, which was residential but did not emphasize relating to the inner self-reorganizing process.
In speaking of the acute episode as a self-healing process, we are confronted with what at first appears to be a paradox for those who think in terms of psychopathology. If the acute episode is a psychosis, then it must, by definition, be disorder, and how can a disorder be healing? Also, if there is no disorder, then what is there to be healed? In my view the "disorder" lies in the so-called prepsychotic personality, that is, in the insufficient emotional life of the individual up to the time of the first break, the emotional aspect of development having been severely limited and inhibited. For these individuals the interchange of feeling has been considered unsafe and intimacy seen as threatening. In many ways their experience has shown that feeling cannot be afforded because of the danger of being hurt. The residence facility is designed to be a safe environment for the expression of emotional intimacy and for the full expression of feelings of any kind, especially warmth; all the various emotions can be released as well as acted upon and responded to. This element has shown itself to be an essential part of the healing process.

A fifth habit of mind that needs to be reckoned with is the preference in our culture for the "quick fix," by which we are inclined to demand of any procedure that it be short, fast, and therefore inexpensive. The medication regimen fits this expectation so well that in the average psychiatric facility the pressure is aimed at having any new case "stabilized" within a week and quickly discharged; if by the middle of the next week this development has not occurred, the staff begin to ask what the problem is and the dosage of medication is increased.

The reason for this haste is, of course, economic: mental health boards and hospital administrations are pressed in this direction by the circumstance that the budgets are drawn up annually, and under various stringencies the allotments are usually cut back each time. Hence if one draws up a detailed five-year trajectory, demonstrating that in the long run considerable money is saved by alternative methods, this proposal falls on deaf ears because of the preoccupation with budgets designed for one year at a time. The conventional sequence of acute care, aftercare, continuing OPD visits with medication adjustments, plus board-and-care costs, all on top of adding one more person each time to the population of minimally capable persons dependent on the county, all mounts up to a huge expense. If the acute episode can be self-healing, why not take advantage of this process and benefit from it?

Now it appears that nature, not being budget-minded, has long since arranged that visionary experiences of various kinds, including acute episodes, have a tendency to take six weeks to accomplish their inner aims. It is intriguing to reflect on the connotations of this, for the
number is recognizable as forty days, with all this time’s connotations: the biblical accounts of the visions of Esdras,\textsuperscript{16} Jesus’s forty days in the wilderness,\textsuperscript{17} or the world-destruction imagery of the Deluge,\textsuperscript{18} all conform to this pattern. Also to these examples can be added the contemporary programs of autogenic training, language learning, and brain washing, all of which are geared to a six-week threshold to take effect. There appears to be something in the programming of the psychic organism that is designed in this particular way. Pacing is an important phenomenon that invites our scrutiny. Our experience indicates that in the acute episode the more floridly disturbed the persons are, the more rapidly they move through it. Intensity seems to correlate directly with brevity of time, and with favorable outcome. The persons who are frightened, overwhelmed with imagery, and engrossed in their preoccupations are the ones most likely to have a favorable inner experience, from which they emerge with significant change.\textsuperscript{19}

At Diabasis we had no little tremor of misgiving when we were told to set the limit of stay to two months, but we found this to be enough time for the live-in segment of the clients’ involvement with us. We added to this then an offer of a third month of daytime stay in a second house in the same circumstances as the first two months, and then again an offer of another six months of regular interviews with the same staff member as before. We joked about this, that it was perhaps not entirely accidental that this time period added up to a nine-month process of being delivered into the world anew!

I cite these several habits of mind in the psychiatric profession and the mental health field in general in order to point out that alternative methods and programs are based upon premises entirely different from those governing our present-day conventional practices. When funding is sought for new alternative ventures in the future, considerable clarity about the differences in presuppositions is imperative. Even more striking among the efforts on the part of psychiatrists to understand psychosis is the persistent pursuit of a principal feature of that syndrome, a disorder of the thinking process, which now calls for our attention.
Chapter 2

Thoughts on Thought Disorder

Although there is some consensus in psychiatry that schizophrenia is thought disorder, there are so many differing and contrasting formulations of it that we need to reflect about the relativity of psychological conclusions.

In our Western culture, as individuality increases so does diversity grow to such an extent that we find ourselves living in different universes. Outwardly we might seem to look and act somewhat the same in some measure, but when we allow ourselves to be seen at a deeper level and reveal our belief system, our value system and our lifestyle preferences, we find ourselves living by almost as many subcultures as there are persons.

Compare our times to the medieval era, for example. The sociologist Sorokin, in his exhaustive study of the cycles of cultures, defined an "ideal" type, such as occurred in the Middle Ages in which a unitary structure of faith and ethics, and of hierarchical political and religious institutions, prevailed. In contrast to such a consensus that gave the spiritual dimension the highest value, our modern era since the Renaissance has granted the highest honor to the achievement of individualism and to an outlook that establishes materialism as the framework of our philosophy of "the good." In this type of culture, called by Sorokin "sensate," the "abundant life," which used to convey the implications of spiritual enrichment, has come to signify the acquisition of things.

In this trend from unity to diversity we find truth becoming increasingly relative. We live by differing truths. Does this imply that truth is illusory and futile to seek? A difficult point for many to grasp is that it is the task of each and all of us to find our own truth, even though consensus may not make its appearance to reassure us.

To be creative is to be original, and to achieve one’s unique individuality is a creative work. As we grow into self-fulfillment we become increasingly idiosyncratic. An accomplished individual becomes in some degree an anomaly!
Surely, one might object, science seeks truth and builds up a more and more realistic definition of nature, and thus gradually reaches a true rendering of it. Yet the more we familiarize ourselves with the history of science and its theories, the more we recognize that science is a creative work and that the most creative scientists are accordingly original by disposition. One of the more exciting features of science is the contention that occurs over differing conclusions, always striving toward a truth that is always elusive in the end.

This particular feature is most startlingly and distressingly evident in the field of psychology. We find it to be a discipline that is as polyglot as can be, with as many theories of personality and mental process as there are psychologists. Every major school of thought among the dozens is different, all viewing human nature in their own way and all contradicting each other. To some this might seem bewildering and appalling, while to others it makes the search for a true theory all the more intriguing. The conclusion that finally becomes unavoidable is that each psychology, each school, is an expression of the personal makeup and standpoint of its originator.

Yet the creative originator’s personality is only one among the factors giving shape to a psychology. Influence on a more general level comes from movements and trends of the culture in any particular decade, becoming reflected in the prevailing frame of thought. This is true not only of psychiatric formulations, but surprisingly pertains even to the very incidence of certain syndromes in psychopathology itself. Studies of records have shown that among the “schizophrenias” there was a high rate of occurrence of catatonic types in the 1920s and 1930s, which then dropped off in succeeding decades to the point of rarity at present. In the postwar period of the 1950s what could be a more natural expression of the temper of the culture than the sharp rise that occurred in the diagnosis of paranoid types? Then came the era of the 1960s with its counterculture and its widespread recognition of the phenomena of altered states of consciousness, especially in the wake of the popular use of psychedelics and meditative techniques. During that and the next decade the most common form of psychosis was the syndrome at that time called “acute undifferentiated schizophrenia,” in which the deep psyche seemed to be opening up so fully as to seem inside out! In another clinical arena, that of the neuroses, hysteria of the conversion type had been in the early decades of this century very common and a subject of much psychiatric scrutiny; it dwindled away to such an extent that it is now quite rare except in certain immigrant populations from other cultures.
Attitudes on the part of the psychiatric profession also have shifted remarkably from decade to decade. I have been privileged to watch these changes through a span of five decades, the most striking being the '60s. With the rise and prevalence of the counterculture in the middle of that decade, the psychiatric residents whom I was teaching and supervising suddenly changed in manner and appearance with beards, bell-bottoms, and beads, all to the delight of their patients. These were heard to exclaim, “This is wonderful! We can really talk to these doctors now!” The destiny of residence facilities as alternatives to hospitalization without medication also reflected the tenor of the times. In 1970 the National Institute of Mental Health (NIMH) was funding experimental research programs such as ours at the Agnew Project to determine who did well without medications. The Diabasis program was made part of San Francisco’s Mental Health System in 1973, but met political opposition that closed it. Upon reopening after two years, we were given the status of facility of choice for the acute first episodes in the county’s mental health system. In another two years’ time the county’s policies recoiled radically into an ultraconservative stand, and although we were decidedly successful and well regarded, we were abruptly cut off from county funding along with all other special services (leaving only two crisis units). Of course, in the ultraconservative 1980s any thought of carrying out such a project became unthinkable.

Although this history of those decades is familiar enough, I am retracing it here in order to make a point about the nature of psychological theories and models. A piece of experimental research or a treatment approach does not lead to a conclusion or formulation that stands by itself as objectively validated “truth.” Rather it should be viewed as a special instance in the context of an entire cultural configuration, as a part in the whole of a cultural set. This societal whole governs in great measure what the part becomes. A psychological formulation seen from this perspective needs to be evaluated in terms of the question whether the investigator is representative of forward-moving trends or of established views about to wane into the background. This suggestion, of course, does not imply that almost anything new is to be valued highly for its newness, although in our rapidly progressing culture this seems to be a habitual tendency. Rather, what is concerned is the deeper issue of whether the new statement participates in the current thrust of a culture pressing on toward ever increasing levels of understanding. Freud was firmly rooted in the scientific framework of the nineteenth century and spoke in terms readily understandable to the profession of his later years. Jung’s explorations were
motivated by a number of interests that became prevalent only toward the latter part of this century. J. B. Rhine’s findings in extrasensory perception were totally unacceptable to the psychological profession of the 1930s, yet they gradually have been granted more general recognition.

In these comments I have been alluding to the fields of psychology and psychotherapy in general, but when it comes to the problem of understanding the “schizophrenias” specifically, the issues need even more urgently to be recognized. I stress this because in the last decade it has become apparent that the negative attitudes toward this condition on the part of the profession have a strong effect on what the condition actually becomes. If, on the other hand, a therapist relates to the thought and behavior as meaningful and representing a crisis in growth and development and the individual feels validated, the psychotic state may then clear up within a quite short time. In recent decades the role of the observer in scientific investigation is being increasingly recognized as playing a part in the process that is being scrutinized; psychiatry would do well to heed the point.

It has become customary for clinicians to lump together the several phases and various types of schizophrenia under the general designation “thought disorder.” This way of viewing the condition overlooks an observation recognized for several decades, namely that the phenomena in the thought disorder category of symptomatology are not seen in the first acute episode, or only rarely. Yet in San Francisco in 1979 the statistical data-gathering did not even differentiate first episodes from later ones, or acute from chronic!

To clarify the terms under discussion, it must be borne in mind that the term thought disorder does not refer to the content of the person’s communications. The content is called “ideation,” which in the descriptions of the schizophrenias is called “bizarre ideation,” signifying ideation that is unusual and not understood. What we are concerned with now is “formal thought disorder,” signifying certain measurable traits that the communication of thought reveals in its form. There is considerable literature on the topic that would take an entire volume to review, and I will comment only on certain highlights of the formulations.

In the various renditions of the topic, it becomes apparent that each springs from an underlying paradigm that is concerned with how the psychic organism operates, and each reveals the investigator’s outlook and view of human nature. There are spokespersons for the more mechanistic framework who find a faulty conceptualizing function, as if it were a damaged tool. On the part of many there is a strong conviction in predicating a “brain disorder,” which reflects the prevailing preference.
for the view that what is physical and chemical is necessarily primary in causation. Then we find systems theory making its mark in pointing to the levels of the general functioning of the total organism as revealing faultiness, rather than the functioning of the parts. There are those who study the errors in logic and find a "paleological level" reached in a gradual retreat from a harsh and frightening reality.

It has been generally held that the principal feature of "thought disorder" is a deficiency in the capacity for abstraction, accompanied by its counterpart, a tendency to understand and express ideas only on a concrete level. This formal "thought disorder," amounting to an object-bound state, is most pronounced in true "schizophrenia" (this term is reserved for a condition lasting at least six months, during which there is a downhill advance of disintegration and deterioration). It is least pronounced in the first acute episodes, the very ones that patients are the most apt to recover from. These early episodes are defined by their duration: if four weeks or less they are "brief psychotic disorder"; if lasting two months, "schizophreniform disorder." This kind of categorizing according to time rather than to the nature of the psychic process is unfortunate but at least leaves room for the claim that the first episodes are not necessarily schizophrenic and should not be called so until half a year goes by.

I will epitomize very briefly some of the salient features of the "thought disorder," as formulated by Goldstein and his contemporaries, in order to compare their general viewpoint with the one that I am advocating. (I have concluded that more recent studies on the topic have become of little value since all subjects of this category are by necessity medicated, thus invalidating the findings.) The picture presented is that both abstract and concrete behaviors are expressions of the total personality, not specific aptitudes. There are changes in the total behavior, of which thinking is only one special expression. Thinking is not operating like a damaged tool but is used incorrectly, due to changes in the broader aspects of personality organization. The language being used reveals the faulty abstraction since words become "individual," implying singular, fitting only specific objects or situations, and become, as it were, "part of the object." This observation encourages the assumption that schizophrenia is fundamentally a brain disorder, inasmuch as patients with organic brain damage show similar abnormalities in language.

Investigators of this disorder find thinking to be not only concrete but literal, manifesting a difficulty with symbols or abstractions and a predilection for unusual symbolism and pseudoabstract thinking. It is said that some thoughts occur that are mistakenly considered to be expressions of symbolic, metaphorical thinking. The term symbols in these
statements signifies the verbal constituents of language, not mythic images: “Symbolic thinking belongs to higher forms of thinking which are equally impaired in schizophrenia.” When it is concluded that symbol formation is impaired and inappropriate, the statement is intended to imply that the language used, that is, to symbolize in terms of words, is not operating according to the rules of rational thought.

Yet in the view I am presenting a quite different species of symbols is at play in the acute episode, not belonging to the realm of rational functioning. Mythic symbols have in this condition supplanted the usual linguistic ones, and are being used to express images heavily laden with energy, thereby arresting the person’s full attention. In the normative state these images tend to build up their own pyramiding hierarchies of structure towards a unitary whole, centered and balancing the opposites, finally embracing most of the vital issues of emotional living. There are, then, two hierarchic structures: the ego-conscious’s rational system of concepts and feelings growing to ever higher levels of abstraction and unification; and the unconscious’s nonrational system of meaning and values in ever deepening levels of imagery and unification. The higher and the deeper levels of symbols are counterparts of each other. Each creates its own experience of realness, its own different realities. The disadvantage of the nonrational systems is that they are not granted recognition and validation by our culture and viewed as representing a different reality, but only a defective one.

This model of the acute episode—in which the “fantasy” reveals forms that are not derived from outside but that express the contents of the deep psyche—offers a clear picture of a certain type of concretization different from that of the formal thought disorder of later stages. It concerns what is done with the ideation, rather than the form of its expression. There is no lack of abstraction, but it takes the shape of the mythic images from depth, rather than from the level of the rational mind’s abstract concepts. The concretizing is found to consist of two persistent tendencies: one is to identify with the most favored of the mythic figures that make their appearance in the visionary process; the other is to project the unfavored ones out into the surrounding world. Instead of speaking of a vision or the felt presence of a divine personage, the individual becomes it; one is then the Second Coming of Christ or is the Virgin Mother or the Love Goddess. On the unfavored side, rather than recognizing the threat of an overturning of one’s system of beliefs and values from within, one is the victim of enemy agents or of CIA sleuths lurking outside the window.

These two features, the tendency to identify and to project, are responsible for the impression of insanity in this process. This effect is
most unfortunate for the fate of the acute process itself: when it is viewed as psychopathology it is thwarted from attaining its goals, while if it were more aptly recognized as spiritual in essence much damage could be averted. For instance, if the need to reconstruct one's world-image within becomes a mission to change the outer world, one of two eventualities can occur: if the person is highly gifted and charismatic he or she might be given a glowing reception as a leader of reforms; if not so endowed, he or she might be consigned to the degrading status of a disqualified outcast. When invalidated, one is seen as an invalid. A society that is religious—in the sense of living by its myth and attending to its demands—tends to value its visionaries and regard them as possessed by the spirit. A culture that is dedicated to secular and materialistic guidelines devalues such persons to the point of extrusion from the participation granted to "normal" people.

The concretization does not follow the lines of the formal thought disorder, but concerns instead the way of relating to the mythic images. These symbolic configurations are highly dynamic and can thus be very inflating. In our kind of culture it is healthier to take them on the symbolic level of understanding and apply them to one's inner life. If one is more than usually gifted, they might be accepted as having value for the culture, providing creative or spiritual contributions.

During my four decades of observing the acute first episode, I have been guided by the view that it is not a question of impairment or damage but rather a shift in energy. When a person finds herself in a state of acute distress, in circumstances that have assailed her most sensitive vulnerabilities, her psyche may be stirred into an imperative need to reorganize the Self. The deepest levels of the psychic organism are activated, and in consequence they draw vast amounts of energy to themselves and away from the higher levels. The whole field of awareness becomes flooded with archaic forms, the myth-styled images that are the natural contents of those deep levels. This condition represents not a flight from outer reality, as a device to retreat from unbearable fears, but a state of being overwhelmed by inner psychic events. The sense of reality shifts from outer to inner, and she finds herself immersed in a mythic world totally out of keeping with the consensual one. If circumstances are favorable at this point, the psyche may embark upon its reorganizational process in its own customary fashion (yet so uncus-

tomary to our usual expectations).

In this framework, therefore, the higher functions are not seen as defective or impaired, but robbed of their energy. Even the physical organism is deprived of its usual level of performance: motivations to care for it drop away as nourishment and sleep are given less heed.
Remarkably, the behavior resembles the preparations for inducing altered states of consciousness by ritual fasting and sleep deprivation. The picture is of an almost brutal demand on the part of the deep psyche that all the reserves of the organism be commandeered to support its urgent processes. It is not that the entire organism is operating at a lower level of performance, but that one part only is functioning at such a high pitch of energy that all the other functions become deprived of it. Roland Fischer prefers the term “hyperphrenia” for this “high arousal state.”

The clinical or psychological symptomatology is then an expression of this state. The person is withdrawn in her “preoccupations” with “fantasy,” which means her whole attention is absorbed in this spontaneous sequence of images. The affect is “dulled” or “inappropriate” until someone is willing to relate and respond to this inner experience. Investigators who put the person through tests are met with resistance, for there is no interest in such games when there are more urgent matters constantly making themselves felt inside, of which the investigator is quite oblivious. Hence an impression of “aloofness” is created; this is ironic since to the person in this state it appears that the tester is the one who is aloof and unconcerned with the momentous things happening psychically.

A most impressive and valuable clinical experiment to measure the effects of invalidation has been conducted by Zarlock. Twenty-five years ago he demonstrated the striking difference between the observable effects of medical and nonmedical regimens. The design was this: thirty men having a diagnosis of reactive schizophrenia and at least three months of hospitalization were observed under four different kinds of environmental conditions. Three of the milieux were nonmedical, being recreational, occupational, and social; a fourth was the medical model setting. Zarlock and other staff members would dress and act in ways appropriate to each environment. The verbal communications were all taped and evaluated in respect to pathological content and linguistic disorders, that is, to signs of thinking disorder. Records were kept of “rough approximations of time patients interacted or communicated with one another and the amount of time devoted to a particular activity.” Patients were found to adopt “appropriate language, relevant content, and proper roles in different environments.” They showed “an ability to behave according to the rules.” Schizophrenic reactions were “almost entirely absent in non-medical settings and only a medical environment seems to have an efficacy to produce the characteristic symptomatology,” since in that setting patients may conform to its tacit demands, in fulfilling which they “may become immersed in pathological language, content, and behavior.”
The one-way communication between patient and therapist characteristic of medical environments effects an isolation or lack of communication among patients as a normal consequence. Zarlock concludes that "the evidence seems to support the assumption that language and role pathology are to some extent artifacts of a medical milieu"; if a person adopts the role of a patient he "may wish to fulfill the demands associated with that particular social position."

The prevailing psychiatric consensus now holds that the failing of the abstract attitude tends to progress malignantly if not put to a stop. This view leads to an injunction, on the part of most hospitals and teaching programs, not to encourage patient's dereistic, that is, non-rational talk, not to listen in a related way to these communications (or at least not beyond the first occasion when it is heard for diagnostic purposes). This policy is held out of the fear that to give too much attention to the nonrational would only support the tendency toward disorganization. Yet there is a contradiction in this line of psychiatric thinking:

It is observed that part of the person's plight is her isolation and social disarticulation. Her attempts at communication are viewed as failing because of the deficiency in the thought process, and in the consequent chagrin, causing increasing degrees of withdrawal to mitigate the anxiety by an "escape from reality" and "retreat from reason." Psychiatry attempts to counter this by urging the person to "socialize" and improve her "social skills," in contrast to her natural inclinations in this state. Heavy medication is administered to mend the thought disorder. This treatment regimen, to restore the socially disarticulated person to her social context, amounts to an all-out attack upon what nature is engaged in doing. She is to be made "normal" again, to help her back to the prepsychotic state; but the psyche is striving to dismantle that previous self in order to reorganize it along new lines.

Thus the person is caught between opposite pressures: one from the psyche to go through disorganization on the way to reorganization, and the other from the psychiatric system to put a stop to that and get back to "normal." Hence a whole new disarticulation is set up by the profession in that the staff will not relate to the person in a way that she would feel them to be connecting with her depth. Thus, if the profession insists upon a nonlistening stance in relation to her inner concerns, the sense of isolation mounts, as does her feeling of disqualification and invalidation by a harsh diagnostic label. All this can only thrust her more into the direction of the very madness and insanity that the treatment is intended to remedy.

We therefore have to ask a hard question. If the signs of "thought disorder" are at a minimum in the first acute episode and most
pronounced in the chronic states, what is it that causes the worsening? Is it due to an insidious disease process that becomes relentlessly aggravated with the passage of time? Or is it that the "patient" feels isolated because the communications that she would prefer to express are blocked by psychiatric policy? I prefer to conclude the latter on two counts: one is that rage is mounting when this blocking happens, and the rage is devastating to the psyche. On the other count, when therapy allows full expression of these innermost concerns of the person, the rage subsides and the disorder clears up rapidly. If this is the case, we owe it to the person to cease trying to correct her behavior and speech and instead to correct our own reception of her concerns. Such a new appraisal of the effects of the psyche's energy shift requires that we open ourselves to the various dimensions of visionary experience in the following discussion.