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Research Paper

An Illness Yours and Mine: Disentangling Complex Dynamics That Determine Treatment in Schizophrenia

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ABSTRACT

Recovery from a Serious Mental Illness (SMI), such as Schizophrenia, is often believed to result from an accurate treatment plan devised by an expert, implemented with the help of a supportive team of care providers. However, limited attention has been given to various processes at the micro, meso, and macro-level and how that determines the course of treatment, skewing outcomes in services. With the help of a case study, this paper attempts to illustrate these processes at a micro-level, which includes an individual's own perception of their illness. An individual's meaning-making of their illness can manifest itself differently in symptom formation and alter an individual's experience of it. At a meso-level, these processes would include care providers' and the doctor's/therapist's perception and meaning-making of the person's distress, their own subjectivity engaging with that of an individual's. 'Schisms' in the psychiatric services (the macro level), with the increasing influence of biological model (over psychological) of exemplifying illness and organizing the services, in turn, can affect the ones rendering those services. The case study presents the material chronologically with respect to the family as a unit and tries to recapture the coursing problems, assumptions, and decisions that beset the family members over the years, eventually entangling them together in a net of circumstances. As the doctor and the therapist are the inevitable strands in the course of disentanglement, the paper also sheds light on a therapist and a doctor's motivation of working with patients who can evoke unease in care providers. The resulting meaning made jointly through the interaction between these complex processes is likely to facilitate recovery and, therefore, need to be addressed.

Keywords: *Meaning-making, Intersubjectivity, Schizophrenia, Recovery*

This paper analyses how in an illness such as Schizophrenia, a patient's subjectivity which is often undermined, can, in fact, be that which can give a glimpse of the patient's inner world. Meaning of the illness cannot be made without considering the patient's subjective experience and their relation to the world. Similarly, understanding a patient's relation to the caregivers and the doctor is equally important because the patient's illness, which can affect those providing care, can further have an effect on the course of treatment. This perspective, against the simplistic and outmoded view of the dynamics involved in illness and treatment in which the wise figure of the doctor determines the

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course of treatment for the patient, a hopeless recluse, who is to religiously follow the doctor's direction while the primary caregivers make sure that the patient does, is a determining factor in the process of healing. This paper attempts to address these themes of psychosis with the help of a case study.

The sub-part: Madness as a need to be believed (micro-system), looks at the importance of seeing meaning in the patient's truth. It elucidates on the therapist's ability to acknowledge the uniqueness of the patient's truth as a condition necessary in working with patients suffering from psychosis. The role of family dynamics in the healing/prolongation of illness (mesosystem) attempts to look at the subjectivity of the primary caregivers, how it interacts with that of the patient, and its importance in determining the course of treatment. Focusing on the larger picture, the macrosystem, the third sub-part: Role of the doctor and the therapist in working with the 'Unwanted patients' (Eigen, 1977), attempts to look at the doctor's and the therapist's own subjectivity, the impact that the patient can have on them, and various other factors such as the dominance of biological approach to illness over the psychological view (macro-system) can all combine to influence the patient's healing process. Finally, the subpart: "What is in it for me?" attempts to understand how helping patients who have lost meaning and the inevitable therapeutic pain involved in helping them can, in fact, be a rewarding experience for the therapist.

A mental health disorder such as Schizophrenia affects multiple areas of the patient's life as well as the care providers (Rus-Calafell et al., 2015). Therefore, understanding these numerous intermingling dynamics are vital in recognizing the challenges that need to be overcome in order to achieve well-being and recovery.

CASE OVERVIEW

"Doctor, every time my kids came back home for vacations, they would experience severe joint stiffness, and I could not make sense of it," quoted the husband of a sixty-year-old woman suffering from schizophrenia. The illness surfaced and disrupted the lives of a beautiful family, of a couple and their two children, when 'the mother,' in her late forties, encountered an accusing sense of self-deprivation in the form of psychosis. She began to believe her kids to be not her own but someone else's, of someone her husband committed infidelity with. The aforementioned statement and an emphasis on her role as a mother might appear to be disjointed strands of information but are nonetheless pieces of a jigsaw puzzle which would, on its gradual formation, reveal the picture of a suffering insanity.

On being at the loss of a mother, if not in a tangible sense but in a sense metaphorical, the father of the two children found it in the children's best interest to send them to a boarding school and then to a college of a city different from their own. Meanwhile, the ailing mother continued her antipsychotic medicines to subdue the symptoms, struggling to find meaning in the illness and to acquaint others with her truth, it being that her children are not her own. The more others disagreed, the more staunchly she asserted what truth was for her. Her children would come home once in a while to see their parents. However, each time they came 'home,' it was the 'house' that they left, left feeling overwhelmed caused by the emotional exhaustion, the exhaustion of an invalidated existence from a mother who would not accept them, and the physical exhaustion the children experienced in the form of joint stiffness, only for it to get better later and happen again the next time they came home. Perplexed doctor, therapist and the father, unable to make sense of the occurrence, left the commonplace affair of joint stiffness to it being a fluke. The obsession with establishing

cause and effect, a tendency so compulsive in humans, led everyone to assume the changed weather, food, and living styles as possible explanations of the temporary joint stiffness. Years passed by with no logical explanation found and lost, until one day the joint stiffness became so severe that the son had to be admitted in the ICU on a visit to the home and all the facile generalizations of changed weather and food lost their potential to justify the ordeal.

Puzzled at the incident and disquieted about his son's health, the father brought together the dispersed pieces together to fit the jigsaw. The final picture revealed that the woman believing the children not to be her own and seeking vengeance for her husband's infidelity, mixed in the children's food her antipsychotic medicines which had the resultant side effect of joint stiffness. A dosage in excess led the son to land up in an ICU. The disheartened husband, laden with feelings of betrayal, asked his wife to leave the house. In her early fifties, living with a suffering so crippling, she left to live with her brother with no place else to go. The woman in time found solace in her brother, not only because he offered to her a shelter in a sense material but also because he sheltered her truth. He believed in what she had to say, in her truth, which others discarded as madness. The question then to ask is what was it about the brother that made for him possible to believe in the authenticity of her being, that which seemed to everyone else, even to the doctor, incomprehensible and alien. Not too surprising, it was his own madness as the brother, too, was suffering from schizophrenia. One might call it a classic case of Folie a deux1, but at the same time, can barely discard the fact that in each other, the two 'outcasts' found refuge. Years passed, and the siblings continued to live together, in a world bizarre to others but real to their being.

The husband, now in his early sixties, with his children tangled in the everyday of their own lives, began to feel extremely lonely. The loneliness, or call it the modern-day-madness, instigated in him the need to reach out to his wife. With multiple attempts and consistent efforts, he could successfully convince her to come back 'home' to the house she was asked to leave. The treatment then began, and gradually, with the help of a supportive team of doctors and the therapist, she began to find meaning in her suffering, parallelly curing her husband of his loneliness and offering her children the object of 'the mother,' the love object lost and found.

This case, of an actual encounter at the doctor’s clinic, brings three important points to be explored:

a. Madness as the need to be believed
b. The role of family dynamics in the healing/prolongation of illness
c. The role of the doctor and the therapist in working with the ‘Unwanted patients’
c.1 What is in it for the doctor and the therapist?

A. Madness: A need to be believed

1 Folie à deux means 'folly of two' or madness that is shared by two people. It is also known as shared psychosis or shared delusional disorder (SDD), a psychiatric syndrome in which symptoms of a delusional belief and/or hallucinations are transmitted from one individual to another.

"Scientific points of view, according to which my existence is a moment of the world's, are always both naïve and at the same time dishonest, because they take for granted, without explicitly mentioning it, the other point of view, namely that of consciousness, through which

from the outset a world forms itself around me and begins to exist for me." -Merleau Ponty, 1945/1962

The salience of this point begins with the question Liang (1965) asked, "How can one demonstrate the general human relevance and significance of the patient's condition if the words one has to use are specifically designed to isolate and circumscribe the meaning of the patient's life to a particular clinical entity?" No matter how diffused a complaint of the person who enters the clinic is, it is to be taken as a given that the person while entering the treatment situation is bringing her existence, her whole 'being-in-this-world,' and it is of great practical importance to consider that a person may have a way of being very different from one's own experience and concept of her being (Liang, 1965). When a patient's actions and words are looked at as that which needs to be comprehended to be able to make sense of their 'being- with-me' as opposed to their 'being-in-the-world,' it reduces their existence to a mere clinical entity. The ability to acknowledge the uniqueness of their truth is an absolute necessity in working with psychotics (Liang, 1965).

Like in the case above, there is no question that the woman is not showing the 'signs' of delusion. However, there is more to it than just that. The certitude with which she believed that her children were not her own, a sense of retribution she felt through 'transferring' her illness, giving her antipsychotics to the children she believed were the consequence of her husband's infidelity, are also valuable strands of information paving way to the patient's inner world and are not just the 'signs' of a 'disease.' With these 'signs' of a 'disease' identified, the treatment began in a way that could bring the woman under the purview of sickness for the treatment plan to be put in place but not in a way that could help her experience subjective well-being, the end result being violence towards her children.

The component lacking is the inability of others, including the doctor, to find truth in her perception of the world. Though a case of shared delusional disorder, how better or worse her condition eventually became, living with a sibling also suffering from psychosis, could not be validated given the limited information, however, what can be substantiated is that the little comfort that she could find with her brother was because, for the first time, someone did not discard her truth. Hence, of significant importance is the recognition of the truth as not consensus but that which is unique to each individual laden with its own peculiarity. In the case above, her statements and beliefs are usually called delusions, but if they are delusions, they are delusions that contain existential truth and are to be made sense of as statements that are precisely true within the terms of reference of the individual who makes them (Liang, 1965). However, the kernel of the schizophrenic's experience of him/herself must remain incomprehensible to others, and that person's distinctiveness, separateness, loneliness, and despair must be recognized. Like in the case above, it is not the woman’s aggression that caused the violence but her underlying vulnerability and fear. Violence and bravery are methods of denying that vulnerability and fear (Hinshelwood & Martindale, 2004). It could also be her way of asserting her truth.

Nevertheless, recognizing and understanding is not to be reduced to a purely intellectual process. For understanding, love is an essential factor, in the sense of the capacity to know how the person is experiencing herself and the world, including oneself. Without understanding the person, one is hardly able to begin to love the person in any effective way (Liang, 1965). Sawyer's (2013) recovery2 is a testimony of this claim by Liang, wherein she mentioned that feeling that you are being understood is the essence of connection, and it is

this connection that set about her healing process after years of struggling with psychosis. The experience of sharing is thus contingent on how it is received (Borg, 2013), and the construction around a patient's illness will depend on the kind of relationship the doctor establishes with the patient (Liang, 1965)

B. Family dynamics in the healing/prolongation of illness

"Every normal person, in fact, is only normal on the average. His ego approximates to that of the psychotic in some part or other and to a greater or lesser extent."
-Sigmund Freud (1994)

Paramount to the healing process lies in the importance placed on the nuances of feeling states and the richness of human subjectivity. A person's subjective experience, however, cannot be understood in its entirety without taking into account her/his culture, familial structure, values, prejudices, experiences, beliefs, support network, and milieu. Even a person's diagnosis of 2 Annita Sawyer, Ph.D., had herself battled with mental illness and thoughts of suicide. She was institutionalized and underwent eighty-nine electroshock treatments pathology, as Sawyer (2013) puts it, would be contingent on the decade one is born in as well as on who is diagnosing the person. This is to say that, as a person's illness is not to be understood in isolation of the economic, the political, and the social the person is in, likewise, the process of healing cannot be understood in isolation of the subjectivity of others around the one suffering.

In the case mentioned above, the healing of the woman began, not with the institutional coercion where the biological approach, usually regarded as the scientific approach, is placed on a dominant position (Hinshelwood & Martindale, 2004), but with her husband's own experience of isolation, which prompted him to reach out to his once forsaken wife, to cure him of his illness in return of hers. The violence inflicted by the woman onto the children, resulting in the deep sense of betrayal experienced by her husband and the children, led to a rupture of their relationship and an eventual halt to the treatment. No matter what the reason for the violence was, whether it was an act of assertion of her discounted subjectivity, or an act emerging from a deep sense of fear and vulnerability, it was violence nonetheless. Nothing changes the fact that the violence had happened, and it was this perceived violence that led the family members to renounce the caregiving function. Thus, it is also the subjectivity of those on the other end that would determine if there is a progression of treatment or a withdrawal of support.

In addition to that, the patient's meaning-making of the world can also impact the meaning that carers find in caring. In Schizophrenia, a major casualty is Meaning. The world of the person suffering loses its Meaning, and in place of that loss, the person reconstructs a new one. However, this reconstructed Meaning emerging from that person's imagination can form compelling hallucinations and delusions, which in turn may cause this person, delusional and frightened, to invalidate the role of the carer (Hinshelwood & Martindale, 2004). This invalidation can be discouraging and demotivating for the carer, which can further alter the value carers find in caring, affect the quality of care the person receives or 'if' the care is received.

Furthermore, the intention with which the carer provides support can also determine the course of treatment and healing. It is usually taken as a given that the carer provides care in a way that is in the patient's best interest. This is not to say that this is never the case, but it

would be an oversimplification of the complex dynamics the patient finds herself in to assume that there is nothing in the caregiving function for the one providing care. In the example above, the husband refused to extend support for the treatment to continue because with the experience of a deep sense of betrayal, his expectations or hope from the relationship lost ground. The children also supported the decision because they lost faith in their mother's capacity to carry out the role of 'a mother.' And it was only with the changing dynamics and situations that the conditions became ripe for the treatment to gain a head start. Moreover, it is one thing to provide help to subdue symptoms and a different thing to do to so to relieve a patient of their pain. The difference is minor yet considerable.

Again, it is not to say that the intention of care is prompted by an ulterior motive. The intention of the carer, like the expectations from the treatment, is also an outcome of the macro system3- the carer, the ill, even the doctor and the therapist are a part of. What deviates from the norm could also be pathologized, and the expectations from the treatment could merely be of gaining a capacity to adhere to the norm and not of acquiring a personal sense of well-being. It is possible for a person to be living in a community and still not be integrated with others. Like Szasz (1991) confirms, that people [like this] are called "mentally sick" mainly because they behave in ways which they are not supposed to behave, that the psychiatric patient is the one who fails, or refuses, to assume the legitimate social role. Thus, an illness as well as healing cannot be understood without first understanding the world the patient brings to the clinic, intersections which are complex, tangled and nearly incomprehensible, but an effort to make it intelligible should nonetheless be made a requisite.

C. The doctor and the therapist in working with the 'Unwanted patients'

"Schizophrenia is an expertise in producing disquiet in others." -Berke (1979)

Responsibility is a biological inheritance, and responsibility for others is our core as ethical animals (Hinshelwood & Martindale, 2004). Responsible for the patient's well-being, a stereotypical imagination of a clinic consists of a benevolent, wise doctor, trying to help the suffering patient and her family, reassuring them of progress while healing the patient of their 3 Macrosystem here is a reference from the Bronfenbrenner's Ecological Systems Theory, where macrosystem is one of the five ecological systems: Microsystem, Mesosystem, Exosystem, Macrosystem, and Chronosystem, with each having an impact on the person. Macrosystem focuses on the cultural elements such as socioeconomic status, wealth, poverty, and ethnicity.

Illness. And if the illness persists, it is because of the patient's own inability to rid themselves of their symptoms, of their compulsion to repeat (Phillips, 2016). The wise and erudite doctor has to then modify the treatment plan to best suit the patient's needs. A picture of the clinic such as this, mainstream, perhaps fantastical, splits this responsibility into two- the patient who has the responsibility to be receptive to the treatment, and the inability to do so is to be worked through by the doctor, that being her responsibility. Looking closely, missing in such an account are (a) the doctor's and the therapist's own subjectivity, who is usually considered to be a detached observer holding up a screen through which the patient's narrative and portrayal are sieved (Karlsson, 2010) and (b) the 'schisms' in the psychiatric services affecting the patient and the treatment plan (Hinshelwood & Martindale, 2004).

To bring into perspective the subjectivity of the doctor and the therapist and its interaction with that of the patient's, Stanton and Schwartz (1954) introduced a term called Parallel process which means that something that happens on the care-providing side of an institution would reflect on the patient. That is to say that the psychological states of the health-care providers and the patient interact. Like in the case above, the evident wish on the woman's side to receive some help for her internal state could not be read by the care-providers, so the violence and the delusion persisted. There was perhaps a problem in reading the plea for help, probably because the doctor and the other caregivers succumbed to playing out the roles in the woman's inner and past life. They were carrying out their conscious tasks, like administering the medicines, making frequent visits to the therapist, and modifying the treatment plan according to the presenting complaints but, they were perhaps unaware of how affected they were by the woman's conflicts and their part in playing them out, probably the reason why their efforts were left unheeded. Such dramatization of the inner worlds of the patient by the ones providing care is a very frequent yet unrecognized phenomenon (Hinshelwood, 1987).

In addition to this, the division in psychiatric services- between the psychological system and the biological system of exemplifying mental health and organizing the services, where the latter has an increasing influence in contemporary psychiatry, in turn, affects the ones rendering those services, determines the course of treatment and skews outcomes in the services (Hinshelwood & Martindale, 2004). This division with an overemphasis on the so-called 'scientific approach' not only undermines the patients' subjectivities but also overlooks the psychology of carers, adds Hinshelwood and Martindale (2004). With the congruence in both these systems, working as one with an equal emphasis on both, the woman's condition began to improve, and so of her loved ones'.

The outcome of congruence that set the stage for healing was the uncovering of 'Meaning.' In schizophrenia, the world loses its meaning, and thus of importance is finding meaning (Hinshelwood & Martindale, 2004). Meaning is also to be found in their symptoms, in looking at those symptoms not as simply being suggestive of a disease fitting into a diagnostic criterion but as a part of one's personhood, not as signs of pathology but as ways of communicating distress and breakdown. One must "bring to bear a diminution of the light - a penetrating beam of darkness; a reciprocal of the searchlight" (Bion, 1990). This is to say that looking at the signs of life through a torch in the dark would mean looking at the pre-identified signs of life, at pre- identified notions. Instead, it is when one casts a beam of intense darkness that some lights become visible, like in the hills, a village on the other mountain becomes visible at night, the light that becomes visible in the dark. It is that meaning, that light which is to be looked for in working with the 'unwanted patients' (Eigen, 1977).

C.1 "What's in it for me?"

On being asked, what is in it for you to deal with such cases, with an illness that can evoke a sense of 'Belle Dame sans Merci' and can possibly impinge on your identity, trigger your mad parts, the therapist treating the woman responded: "Some sacrifice is inevitable to create a capacity to reach one's true self, to understand one's unconscious processes." The wisdom of the statement lies in the acceptance of the unavoidable therapeutic pain as a requisite for "an ascetic as well as a rewarding vein that runs through the therapy" (Eigen, 1977). The therapist, in the process of facilitating help, can become sensitive to her negative and positive states as a source of knowledge about herself, about the patient, and the various

forms their relationship takes (Eigen, 1977). Such a patient, who tends to evoke a sense of distaste in others, also evokes tendencies and images of a "radically primitive and archaic nature," as Eigen (1977) puts it, giving the therapist unusual opportunities to experience and incorporate phobic structures embedded in her psychic foundations. The possible danger in such a pursuit is capitulating to a way of being "permeated by schizoid self-effort and self-attentiveness." Although, this may also serve to develop the therapist's consciousness, adding to her capacity to know and experience. The ideal outcome being enormous growth in personality and self-healing that outgrows the use of manic defences and self-hardening (Eigen, 1977).

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