Three Dangers: Phenomenological Reflections on the Psychotherapy of Psychosis

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Abstract

Background/Aims: This paper offers a hermeneutic-phenomenological perspective on three dangers relevant to the psychotherapy of an underserved and often poorly understood population: persons with schizophrenia and other psychotic conditions. **Methods:** The discussion offered relies on analyses offered by Heidegger (on the “forgetting of the ontological difference”), Husserl (on the nature and importance of intersubjectivity), and Levinas (on appreciating the “infinite” of human experience, versus adopting a “totalizing” attitude). **Results:** The three dangers are: (1) that of neglecting the ontological horizon or overall framework dimension of altered experience in favor of a preoccupation with more obvious, content elements of experience (e.g., by focusing overly much on specific delusional beliefs and their apparent falsehood, rather than on *how* delusions may be experienced and how literally they may, or may not, be taken); (2) the danger of overemphasizing the relevance and need for direct interpersonal interaction at the expense of

appreciating issues concerning the implicit, intersubjective sense of sharing (or not sharing) perspectives with other persons; and finally (3) the error of being overconfident of one’s ability to grasp the patient’s subjectivity. **Conclusion:** The paper explores how phenomenology’s general perspective may offer a helpful alternative or supplement to some widespread attitudes and practices.

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Introduction

Most experts who have pondered the implications of phenomenology for psychotherapy have focused on phenomenology as an overall attitude or mode of understanding, rather than as a potential source for generating new therapeutic techniques [1].¹ (This has not, however, precluded the advocacy, by some authors, of certain existing techniques and the criticism of others: e.g., arguing that so-called third-wave cognitive-behavioral therapy, CBT, approaches may be superior to the second wave

¹ I thank Clara Humpston and Borut Skodlar for their excellent suggestions on revising this paper.

when applied to many patients with delusions [2–4]).² Not surprisingly, given phenomenology’s basic orientation, much emphasis is placed on the importance of grasping, as best one can, what it must truly be like to *be* the person or patient in treatment. But just *which* aspects of phenomenology’s (and the patient’s) overall attitude should be borne in mind? – one may ask. And just *how* does phenomenology’s general perspective offer a helpful alternative or addition to current and widespread attitudes and practices?

In this paper, I shall attempt to offer some general answers to these highly general questions, putting major emphasis on the fundamental orientation of understanding and interpretation that is at issue. I will do so by considering three kinds of danger, three sources of error to which psychotherapy may be prone, and that some phenomenological reflection might help us to acknowledge and perhaps to avoid. Each of these dangers can be described as involving a failure to appreciate a key feature of human subjectivity or existence: (1) its *ontological* dimensions; (2) its essentially *intersubjective* (as distinct from interpersonal) nature; and (3) its *infinite*. Whereas the first issue is most succinctly expressed in Martin Heidegger’s notion of the “forgetting of the ontological difference” (a concept explained below), the second, concerning the concept of intersubjectivity (also to be explained below), was clearly stated by Edmund Husserl [5] and later enriched in the work of Heidegger, Merleau-Ponty, Sartre, and several others. The third is captured by Emmanuel Levinas’s [6] distinction between a “totalizing” attitude and one that does appropriate justice to the “infinite” quality of the subjectivity of a human other, that is, to its inexhaustible and irredeemably mysterious nature. The focus here will be on the relevance these issues have for the psychotherapy of people with psychotic disorders and/or in the schizophrenia spectrum – though some of the points might well apply to other forms of mental or emotional disturbance as well.

² “Third-wave” CBT refers to approaches that claim to go beyond the orienting assumptions of second-wave or cognitively oriented approaches, such as that of Beck, usually by incorporating techniques (such as mindfulness or the notion of the dialectic) supposedly not contained in the earlier waves. Hayes and Hofmann [31] describe new behavioral and cognitive approaches based on contextual concepts and focused more on the person’s relationship to thought and emotion than on their content. Third-wave methods emphasize mindfulness, emotions, acceptance, the relationship, values, goals, and metacognition. New models and intervention approaches include acceptance and commitment therapy, dialectical behavior therapy, mindfulness-based cognitive therapy, functional analytic psychotherapy, metacognitive therapy, and several others.

The Ontological Dimension

Perhaps the key theme in all of Heidegger’s [7] work (and indeed, perhaps of phenomenology itself) is the ubiquitous source of error in human understanding, and, in particular, in our *understanding* of human understanding, that he termed the “forgetting of the ontological difference,” or sometimes just “the forgetting.” The “forgetting” to which Heidegger refers, which involves both neglect and distortion, derives from the widespread and deeply rooted tendency of human thought to focus on objects or entity-like phenomena to the exclusion of broad and more encompassing dimensions or frameworks of experience, and also (a related tendency) to conceptualize or construe what pertains to the latter (frameworks) in terms of the former (objects). What this has meant, in much of psychopathology and psychotherapy, is that the relevance, or even the possibility, of a different *mode* or *form* of experience, on the part of the patient, is not adequately recognized. Attention goes, instead, either to the apparent *content* of the patient’s mental life (e.g., *what* beliefs his delusions may include) or else to the errors inherent in what is assumed to be an experiential orientation that, though defective, is (supposedly) essentially similar to that of normal life.

This tendency to focus on the ontic and to neglect the ontological is prominent even in many psychological approaches that are critical of the reductionism of mainstream views. A good example is an excellent recent article by Borsboom, Cramer, and Kalis [8], with the title “Brain disorders? Not really.... Why network structures block reductionism in psychopathology research.” In this article (admirable in so many ways), the authors argue that mental events not only cannot be reduced to the physical plane, but must be recognized as playing a causal role in the development of symptoms, given that *experienced* meanings, such as the thought “the CIA is spying on me,” may well lead to other symptoms, such as withdrawal from social life (p. 20). Borsboom et al.’s central polemical point is both important and well argued. It is noteworthy, however, that even these authors, who argue so cogently for the importance of subjective life, present mental life almost entirely in terms of what they term “the content of mental states,” referring thereby to the “intentional content” of “belief-desire talk” as defined in the “interpretivist” approach of such philosophers as Donald Davidson and Daniel Dennett. In doing so, they neglect the importance of the more overall, in a sense mood-like, attitudes, orientations, or atmospheres to which Hei-

degger and other phenomenologists would draw attention, these latter having more to do with what might be termed the *form* rather than the *content* of experience, with the “how” rather than the “what” of one’s experiential life [9]. Borsboom et al. [8] explicitly associate the attempt to “put ourselves in the patient’s shoes” only with the discernment of “rational relations” between mental contents, as with means-end reasoning and the like. There is no mention of issues such as the nature of associated anomalies of core self-experience or of the alterations of the perceptual world that can occur in predelusional states. Thus, for example, they accept without comment the standard but inadequate definition of delusions as a matter of entertaining and believing mental contents (specific delusional claims about reality) that fail to correspond to external reality – a notion whose inadequacy has been widely recognized (see e.g. Spitzer [10]) and that has been especially criticized in the phenomenological tradition [11].³

Examples of this kind of forgetting and associated distortion or misrecognition of the nature of subjective life⁴ can be easily found across various schools of psychotherapy; it may be especially problematic in the treatment of psychotic disorders. The focus on the content of particular delusional preoccupations is absolutely central, for instance, to Freud’s only extensive study of a psychotic patient, his analysis of Judge Schreber. Freud’s focus was largely on the sexual content of Schreber’s delusions or quasi-delusions. This is by no means an uninteresting or unimportant feature of Schreber’s mental life. Freud and most subsequent psychoanalytic writers on Schreber have, however, neglected another crucial dimension of Schreber’s experience, which might be described as the nonliteral and quasi-solipsistic *way* in which Schreber spoke of an experience what he called his “nerves” and “rays” (which were the central elements of his entire delusional system) – something that is at odds with Freud’s assumption that Schreber’s reality-testing is flawed. This neglect, I would argue, is bound up with a failure to recognize the ways in which these entities can be read as symbolizing the intense and alienating forms of self-consciousness that are at the very heart of his psychotic world (where they undermine what might be termed Schreber’s “center of experiential

gravity” [12]), and that may constitute the key dynamics of the suffering he undergoes. (For a discussion of this aspect of Schreber, see Sass [13].) This, of course, is but a single example, albeit a paradigmatic one, given Schreber’s canonical status within psychoanalysis. The psychoanalytic focus on particular meanings or entities and their presumed psychodynamic meanings can take many forms and may often lead to a better understanding of the patient’s concerns, whether conscious or unconscious, especially as these may be rooted in childhood memories. I do not deny the value that such a perspective may have, both for understanding and explanation and for therapy. It is nevertheless striking to register the extent to which a focus on symbolic meanings (often sexual, but also, in more recent years, more generally interpersonal) have been accompanied, within psychoanalysis, by a concomitant lack of interest in the fundamental abnormalities of self- and world experience that phenomenologists would see as crucial for grasping the nature of psychotic lived worlds.

This neglect of the ontological dimension is no less characteristic of CBT and other cognitivist approaches to the explanation and treatment of psychosis. The focus here has not been on the psychodynamic interpretation of motivational meanings of particular delusional contents, but, rather, on the supposed error-proneness and reasoning biases that are believed to account for the development and maintenance of delusions (e.g., the jumping-to-conclusions style, externalizing attribution bias, theory-of-mind deficiencies; see e.g. Garety et al. [14]). Phenomenologists argue, rather, that delusional or so-called delusional material is often more reflective, not of a decline of rational capacity, but rather of a withdrawal from social, practical, and bodily grounded modes of everyday experience [15].

This is not the place to debate the relative merits of a traditional and exclusive reality-testing model versus one that emphasizes, rather (or as well), the role of phenomena like double bookkeeping, quasi-solipsism, or the general relevance of a withdrawal from practical and shared modes of experience [11, 13, 15, 16]. It seems clear, however, that *if* one accepts the relevance of these latter, phenomenological interpretations, one would likely be drawn to therapeutic approaches that place less emphasis on the correcting of cognitive bias or inference processes than on ways in which the patient might be drawn into a more practical and engaged relationship with physical reality, with his or her own bodily presence, and with the shared common-sense reality of intersubjective life. Instead of CBT for psychosis, which empha-

³ Jaspers [32], e.g., states that this criterion (of failing to agree with external reality) is only a “mere external characteristic” of delusion and does not get at the “psychological nature of delusions” or the “original experience” on which they are based.

⁴ This would be a form of what Lacan (very much a Heideggerian in this respect) called *méconnaissance*.

sizes bringing the patient to see the irrationality of her beliefs⁵ (and which risks exacerbating the sense of self-alienation [2]), one might look favorably on various forms of body-oriented therapy, dance and other art therapies, and activity therapy of various kinds (e.g., Röhrich [17]) – with the hope that the patient’s shaky sense of basic self and uncertain embeddedness in the world could be improved; and that, with this, the delusional or quasi-delusional orientation might be overcome or at least rendered less dominant.

To understand how this could be, one needs to consider mental life not merely as a Cartesian theatre for the display and processing of proposition-like thoughts, but as having a more encompassing dimension, such as is implicit in the notion, well-known in phenomenological psychopathology, of the “delusional mood” or “delusional atmosphere.” In such a mood or atmosphere, random stimuli or objects may pop out or loom up in the field of awareness, thereby taking on a kind of uncanny and ominous significance that can, in turn, inspire delusional or quasi-delusional interpretations. This mood or atmosphere does not, however, emerge from nowhere, nor is it unrelated to the attentional stance and overall experiential orientation of the subject in question – whose often transfixed look, grounded often in a paradoxical-sounding combination of passivity and of intense attention (what might be called a kind of “truth-taking stare”), plays a crucial role in engendering this atmosphere. A phenomenological orientation to the psychotherapy of delusions would place less emphasis on how delusions can be refuted with empirical evidence or logical analysis, and more on altering the conditions that inspire and perhaps sustain them. And this, in turn, would shift the focus of the treatment away from the delusions themselves, and more toward encouraging actual involvement with practical activity and in social shared forms of experience. It would also involve attempts to lessen the patient’s anxiety and arousal level, given that anxiety fuels the very attitude of petrified hypervigilance that seems to encourage such developments.

⁵ According to Beck [33], we need to demonstrate to a patient “that a particular belief is wrong or dysfunctional and that another belief is more accurate and adaptive.”

⁶ Re metacognitive therapy, see e.g. Moritz et al. [34]. Another CBT approach compatible with a phenomenological perspective is the innovative work of John Teasdale [35], whose notion of the “mind-in-place” (a phrase borrowed from Robert Ornstein) is reminiscent of the phenomenologist Heidegger’s emphasis on being-in-the-world and could almost be described as Heideggerian in its emphasis on mood states and of overall frameworks or horizons of experience.

I have focused here on delusions and the delusional mood, but similar arguments, and similar recommendations regarding therapeutic approaches, might well apply to other domains of psychopathology in schizophrenia. Auditory verbal hallucinations seem, for example, also to be dependent, at least in part, on the general experiential and attitudinal orientation of the subject. Research shows that such hallucinations have a “quasi-agentive” aspect [18], and that patients themselves frequently discover, on their own, diverse ways of alleviating them, whether via engagement in familiar physical activities, by removing themselves from anxiety-provoking social situations, or by willfully adopting forms of inner detachment [19, 20]. Perceptual anomalies and various disruptions of normal thinking processes constitute still other domains of abnormality that may involve similar issues of attitude and orientation, and that can also be improved through a focus on bodily engagement, activity, and a seeking of consensuality.

It would be wrong, however, to draw too sharp a distinction, at least on this level, between phenomenological recommendations and current CBT techniques. CBT therapists (as well as psychodynamic therapists) are certainly aware of the need to alleviate anxiety, which is well recognized as having disruptive effects on cognition. CBT therapists have also come increasingly to stress the helpfulness of a positive therapeutic alliance – a point long emphasized by psychodynamic therapists. Most theorists of traditional CBT for psychosis do seem reluctant, however, to acknowledge that such a relationship may well have an equal or even more significant therapeutic impact than do any of the specialized techniques of CBT for psychosis, such as the focusing on logic or the proper sifting of evidence. Of special interest, however, is the fact that some of the more recent or third-wave CBT approaches seem to be more compatible with an overall phenomenological vision, given that they are more inclined to emphasize the crucial importance of a patient’s overall orientation to experience (as in mindfulness techniques, and perhaps in metacognitive therapy), or of adopting an active and goal-oriented stance (as in acceptance and commitment therapy).⁶

We see, then, that a key implication of a phenomenological approach is to alert us to the importance of the general orientation or attitude toward existence, and the associated overall framework of understanding that is present in a given patient at a given moment or period of time, rather than to allow these more general, ontologically relevant dimensions or horizons to be neglected while one focuses, perhaps overly much, on the particular thoughts or perceptions that may occupy the patient’s (or the therapist’s) focus of attention.

Intersubjectivity

The second danger, and associated warning, concerns intersubjectivity, a topic that has already been mentioned but not yet explained. The terms at issue have been used variously and risk being misunderstood. Here I am using “interpersonal” to refer to experience that is oriented *toward* another person or other people as a more or less direct *target* or *object* of one’s attention or awareness, and “intersubjective” to refer to the presence of the human other as a kind of *implicit participant* in at least some of one’s own acts of awareness, especially perception. Here we might speak of needing to avoid a “forgetting of the *intersubjective* difference,” referring to the danger of neglecting the distinction between the intersubjective and the interpersonal, with a focusing on the latter (interpersonal issues) even when it is the former (intersubjectivity) that should be our prime concern. (There is a parallel here to the ontic/ontological distinction, since the other is *object* in the first case, therefore “ontic,” and part of the overall horizon or perspective in the second, therefore “ontological.”) An overemphasis on the interpersonal at the expense of the intersubjective can be criticized on general grounds and in relationship to both theory and practice, but also in its application to schizophrenia spectrum or psychotic conditions in particular.

The general critique would remind us that other persons are important not only as real objects or even images with whom we interact, whether in action or fantasy, but also as *perspectives* with which we may identify or in some sense share. It can be argued, for example, that the difference between the modalities of perception and imagination has intrinsically to do with the fact that objects of perception are experienced as existing in a shared space, where other subjects can or could see the object in question, whereas this is not the case for imagination. Psychoanalysts with a somewhat phenomenological inclination have indirectly acknowledged this issue – as when Winnicott [21], in a well-known essay, argues that the “capacity to be alone” actually depends on precisely the sense of feeling a shared, internalized presence, or when more recent psychodynamic and cognitive thinkers speak of “mentalization” or of “minding minds.” It is, however, Husserl [5] who has described the crucial sense of reality itself as being grounded in the *perspective* of others, in the implicit awareness that other people can or could experience the same object as I myself am now seeing.

There is nevertheless a tendency (by no means universal) to focus more on the overt, so to speak, face-to-face issues of interpersonal interaction than on the more im-

PLICIT realm of intersubjectivity (where the issue pertains, rather, to the presence or absence of a shared perspective on some object of experience). What this has meant, often, is that the focus of both assessment and therapy has been on interpersonal relationships and the grounding of actual social interaction, often with the assumption that encouraging more interaction is a desirable therapeutic goal. It can mean as well, in some schools of thought, that the focus of psychotherapy should be either directly on the here-and-now and, so to speak, eye-to-eye contact of the therapist-patient interaction, or else on the somewhat less immediate nature of the client’s current interactions, outside the therapy session itself, with important others. The rationale for either of these emphases seems obvious enough and makes good sense with many clients. They may, however, be less than optimal or even counter-productive with many clients with psychotic disorders or in the schizophrenia spectrum – for a couple of reasons.

The first reason is that people on the schizophrenia spectrum may well prefer, and indeed may function best, in circumstances that allow a considerable amount of solitude and in which social interaction is neither too frequent nor too intense. For some such individuals, this can be bound up with a sharply idiosyncratic or contrarian set of concerns [22, 23], and they may experience it as a choice. Others may have stronger social yearnings yet shrink away from actual interactions because they offer, too often, a disconcerting source of stress. An ethnographic study in Montreal [24, 25] showed that patients diagnosed with schizophrenia who were allowed to find their own preferred level of social interaction (a form of “positive withdrawal”), which might seem fairly minimal to many individuals, were the ones who fared best and avoided the need for rehospitalization. One representative patient, for example, stayed almost entirely alone, but was very attached to his daily visits to two little restaurants where he knew by name a waitress who seemed friendly toward him, and with whom he could briefly converse.

It is well known that people with schizophrenia tend to be uncomfortable in social interactions. Insight into the sometimes uncanny anxieties that such interpersonal interaction can invoke is suggested by the discomfort such persons often feel upon meeting another individual’s gaze, which means, of course, looking, at least briefly, into their eyes – an experience that may invoke in such persons uncanny or cosmic feelings that may unsettle one’s familiar sense of boundedness and stability:

“I feel gazes of other people as piercing, as if stabbing into me.”

“When someone looks at me, I feel exposed. I feel embarrassed that the other can literally ‘see’ my interiority.”

“I worry that when I look at people I may be injuring them somehow.”

The eyes of other people may also appear like “strange marbles” or seem to have a disconcertingly “glassy” or “metallic” sheen. Alternatively, their eyes may be acutely felt to open into a “mystic,” “cosmic,” or “spatial” dimension – all of which might be termed “difficulties with the gaze” [26].

Such experiences may at first sound odd to many people outside the schizophrenia spectrum. They become more understandable, however, if one can recall personal experiences of staring too directly into another person’s eyes or eyeballs; for the latter, if prolonged, is an experience that is indeed inclined to evoke unsettling feelings of various kinds – whether these be the mutual staring-down of aggression, or the metaphysical weirdness of encountering a glassy *thing* (the eyeball) that apparently looks back at oneself and that is nevertheless (as one also knows) the centrifugal generator of a whole subjective universe – the Other! In this sense, in fact, people with schizophrenia may well be more tuned-in to, or less able to avoid or ignore, what more normal individuals sense but manage furtively to avoid.

Be that as it may, it does seem that too direct a focus on the immediate one-on-one interaction with a therapist, most potently but not exclusively epitomized by direct eye-to-eye contact, can be counterproductive with many such persons; and that what *is* more helpful is the kind of sharing – no less intimate perhaps, though more subtle – that occurs when two people take some third thing as their shared object of attention. One psychiatrist colleague described to me a young woman with schizophrenia who was very attached to her mother, whom she would visit every week, but with whom she would speak almost exclusively about their common interest in horses and horseback riding. For her, this form of interaction – involving implicit intersubjective sharing without a direct interpersonal confrontation or mutual focus on each other – seems to have provided just the kind of predictable, unthreatening, not-too-direct contact that satisfied her need for intimacy without unsettling her sense of self or

of the other. It might provide a sort of paradigm example for the therapist as well, one that might remind the therapist that the most helpful forms of intimacy may sometimes be oblique rather than direct.

The implicit sharing, even intimacy, implicit in such interactions may be helpful in various ways. Of particular interest is its possible role in clarifying or showing up certain experiential distinctions that have a tendency to erode or dissolve in schizophrenia, often with disconcerting consequences.

A key feature of schizophrenia is what can be called the disturbance of one’s “grip” or “hold” on the field of awareness, and this can involve a characteristic uncertainty about the modality or modal structure of experience, especially concerning the potential distinction between perception, imagination, and memory. Such persons can sometimes be fairly certain about the *object* of their experience, but be quite uncertain about its modality or its reality status, resulting in a “confusion of realms”:

“I don’t know, when I talk to you [his therapist] whether I’m having a hallucination, or a fantasy about a memory, or a memory about a fantasy.”

“Real day time scene seems to be part of a dream I had” [26].

One likely source of such modality confusion (there may be others as well) is the tendency toward withdrawal from interpersonal and especially from *intersubjective* existence that is characteristic of many such individuals. As already mentioned, the philosopher Edmund Husserl [5] (see also Ratcliffe [27]) emphasized how the very distinction between perception and imagination is intrinsically bound up with this issue, given that to perceive, in what he called the “natural attitude,” is to experience something with the implicit sense that that something is simultaneously available to other experiential subjects, or could be present (one may perceive, after all, even when objectively alone), in the same shared world.

People with schizophrenia, however, will sometimes isolate themselves, whether in a literal sense or in the more internal, psychological sense of ignoring the perspectives of others even as they live among them.⁷ It would be mistaken, of course, to assume that such drift or ambiguity is always or necessarily a bad thing, or to discourage all solitude on this basis. Certainly there are many in the Western tradition who would disagree with any such claim – as, e.g., those drawn to surrealism, as well as many others, since Romanticism and before, who have recommended the infusion of more dream and imagination into everyday life – as a preferred alternative to accepting what one early 20th century writer, Robert Musil,

⁷ The latter (ignoring the perspective of others) may be an important psychological correlate of what, on the neural plane, can show up as the prominence, in schizophrenia patients, of the “default mode network” (which is generally associated with mind-wandering and self-referential mental activity) even during “task-positive” conditions involving practical action or social interaction, when the central executive network would usually dominate [36].

called the (sometimes dreary) “utopia of the status quo” [28].

It is also the case, however, that more control over the timing and extent of this drift can be useful, and that the ability to snap back at times into the intersubjective harness of the natural attitude, with ease and at will, is obviously useful for adapting to life in its unavoidable practical and social aspects. We should not *fetishize* this ability as the only or main criterion of human worth – as is, perhaps, so often the case when psychiatric experts speak of “appropriate” or “inappropriate” behavior or thinking. Still, only a misplaced romanticizing of rebellion could deny the value either of the ability to adapt to consensual reality or to live, at times, in an imaginative register that is not prone to being *confused* with such reality. And it is this, perhaps, which can be gained through interacting with a sympathetic and nonintrusive therapist, one who allows the patient his own space and who does not insert her own presence, or the need to talk always of “relationships,” too directly into the therapeutic encounter. The strengthening or clarification of implicit intersubjectivity that occurs when two people speak about (triangulate upon) some topic beyond themselves – it is this, perhaps, that should be considered a particularly important dimension of psychotherapeutic interaction with patients on the schizophrenia spectrum.

It would be oversimplified to assume, however, that relationships themselves may not also, at times, be appropriate topics of discussion in the therapeutic encounter. Indeed, once sufficient familiarity and trust is established with the therapist, patients may well find it useful to have an opportunity to describe and discuss such matters as how the presence or direct gaze of another person can engender anxiety. Another complicating factor is that the sense of being seen by another person is not, of course, always and only a potential source of ontological anxiety, either in general or for those with psychotic or schizophrenia-spectrum conditions. Indeed, to be seen by another can also be a source of *confirmation* of one’s own existence, both as a unified being and as existing in social space. The therapeutic relationship has the potential to serve this purpose as well, and this may well require some emphasis on the interpersonal dimension.

Infinitude

The third danger or set of dangers is particularly complex. Here I will attempt to be maximally succinct, without, I hope, verging on the cryptic.

The danger in question involves the risk, within phenomenology and psychotherapy in particular, of a kind of overconfidence and oversimplification, and of a *communicating* of this attitude, that would be reminiscent of the very objectifying tendencies to which phenomenology has always been opposed. This danger is perhaps best captured by the phenomenological philosopher Emmanuel Levinas [6] when he argues against any “totalizing” of one’s awareness of the other and in favor of acknowledging the “infinitude” that is the true index of an authentic encounter with the measurelessness of the human other.

In speaking of infinitude Levinas was acknowledging the ultimate unknowability and unpredictability, hence the mystery, of any human other whose reality is truly registered. Clear examples of the opposite or “totalizing” attitude would be a behaviorism that believes it can sum up (totalize) the person by describing overt behavior, an objectifying model that thinks it can capture the individual by listing his or her basic traits or personality type, or a reductionistic focus on supposed unconscious motivations. All three are totalizing to the extent that they assume or convey that behavioral, trait, or psychoanalytic descriptors are, so to speak, all there is to know or all one needs to know in order to understand a given person.

Phenomenology’s interest in subjectivity, in the person’s *own* perspective or lived world, clearly distinguishes it from these overt forms of objectification. It does not, however, render it immune to all forms of totalizing, for there is always the possibility that its own, distinctive forms of generalization could be reified, essentialized, or accepted too uncritically. This would indeed be the case if a devotee of phenomenological psychopathology were to take any particular phenomenological account (of, say, disturbance of ipseity or minimal self, of common sense, or of vital contact with the world – to mention some prominent phenomenological concepts) as offering utterly reliable and all-encompassing accounts. It is not that such theories should be rejected. It should always be recognized, however, that these are possible *interpretations* rather than final, encompassing truths – and that, as such, they may well *over-emphasize* certain aspects of existence even as they *under-emphasize* or even neglect others that are by no means trivial.

There are debates within phenomenological philosophy about how literally to take Edmund Husserl’s talk of seeking what he repeatedly termed “apodictic” certainty in phenomenological description. Martin Heidegger’s account of phenomenology as a *hermeneutic* or interpretative enterprise, an always partial, uncertain, even, at times, metaphoric or poetic mode of description, does seem to

harmonize more naturally with Levinas's critique of the totalizing ambition. On the intellectual level, it may be useful to remember the strangeness and difficulty, indeed what might be termed the near-impossibility of the phenomenological enterprise itself – with its quixotic aim of turning subjective life, the unending and ultimately unknowable Heraclitean flux, into a kind of *object* of intellectual understanding. (The extent to which this kind of modesty was already present, as a potentiality, in Husserl's philosophy, is an eminently debatable issue; see especially Eugen Fink's *Sixth Cartesian Meditation* [29].)

The discomfort inherent in finding oneself to be the object of a would-be totalizing gaze, even if (or perhaps especially if) this gaze is directed at the interiority of one's experiential life, should not be hard to understand: most of us bridle if we feel that an interlocutor thinks we can be summed up in too simplistic, and thus quasi-deterministic, a fashion. It is easy to understand that anyone in the role of "client" or "mental patient" should feel the same, albeit even more intensely so given the stakes involved and the power of the institutional gaze. Phenomenologically oriented therapists therefore need to remain aware not only of the potential intellectual inadequacy and partiality of any phenomenological interpretation they may adopt, but also of the potentially deleterious effect, within the treatment, that overconfidence in any such interpretation could have on the patient's sense of trust and, more generally, on the therapeutic alliance.

The failure to appreciate the (Levinasian) infinitude of the other seems to have the potential to occur in two different ways in the psychotherapy of serious mental illness – one involving too much emphasis on *difference*, the other too much emphasis on *sameness*. The first would involve constant recursion, in the therapist's mind, to the assumed (even if *accurately* assumed) *otherness* of the patient with whom one is sitting, so that one would be thinking too much of, say, issues of fundamentally altered self-experience even at moments when it might be more helpful, and more truly empathic, to consider the more standard human concerns (about love and respect from others, for instance) of which the patient may be speaking or to which he may be alluding. Here it is Harry Stack Sullivan's [30] famous line – that the person with schizophrenia is "more simply human than otherwise" – that needs to be borne in mind. There is, however, also the equal and opposite danger. This is that of assuming (and perhaps of flattering oneself for assuming) too readily that the patient's concerns are really just like one's own, thus readily open to one's empathic identification; for this is a danger that could risk the "forgetting of the ontologi-

cal difference" discussed in the first part of this essay. It would mean ignoring, say, the ways in which profoundly altered self-experience (including a proneness to experiences of fusion or confusion with the other, or of extreme self-distancing or nonexistence) might alter the way in which the standard concerns are experienced.

How, then, can a well-meaning therapist navigate between the Scylla of *othering* the other and the Charybdis of overly complacent and uncritical forms of empathy? To this question there is, of course, no simple answer – as we all know, the practice of psychotherapy involves an encounter between two flawed human beings, and, even when manualized, remains more an art than it is a science or a technique. My purpose in this essay has been to point out some of the shoals on which the psychotherapy of schizophrenia or related conditions may run aground, and to illuminate some underlying phenomenological principles that might help us to navigate these difficult waters.

Conclusion

I have discussed three dangers that bear on the psychotherapy of schizophrenia and other psychotic conditions: (1) that of neglecting the ontological or overall framework dimension of altered experience in schizophrenia in favor of a preoccupation with more obvious, content elements of experience; (2) an overemphasis on the relevance and need for interpersonal interaction at the expense of appreciating issues pertaining to the implicit intersubjective sense of sharing (or not sharing) perspectives with other persons; and (3) an overconfidence on the part of the therapist in his/her ability to grasp the subjectivity of the patient.

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