Featured Articles

Existential Oppression Faced by Individuals Having Psychosis and Schizophrenia

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Schizophrenia is really a syndrome manifested by marked changes in the afflicted individual's functioning, perception, thinking, and behavior. The onset can be sudden or can take many years to reach some critical threshold in which the "illness" becomes so observable forcing some type of action or intervention. It is thought to arise from gene–environmental interactions within the context of a diathesis–stress milieu. An often ignored area of inquiry by biomedical researchers and/or biological psychiatrists involves an exploration of how existential crises relate to symptoms of psychosis and how existential issues arising from the modern treatment of schizophrenia are likely to be involved in causing some (or the majority) of the long-term morbidity associated with the syndrome. I describe some existentially oriented psychological models linking existential crises to symptoms of psychosis and summarize qualitative research demonstrating that the existential needs of many individuals diagnosed with schizophrenia remain disregarded despite aggressive biomedical psychiatric treatment, and, as a result, often lead to existential oppression and ongoing infirmity.

Keywords: existential crises; oppression; psychosis; schizophrenia

Schizophrenia[1] is really a syndrome that is manifested by marked changes in the afflicted individual's functioning, perception, thinking, and behavior. The onset can be sudden or can take many years to reach some critical threshold in which the "illness" becomes so observable forcing some type of action or intervention. Most individuals experience some type of prodromal phase characterized by gradual deterioration (e.g., social withdrawal, loss of interest in school or work, poor attention to personal hygiene, strange behavior, and episodic outbursts of anger) forcing acquaintances, friends, and/or family members to recognize that something is wrong, although they might not be able to fully recognize just how severe the situation is (Schultz, North, & Shields, 2007). Eventually, however, these afflicted individuals manifest overt symptoms of psychosis (i.e., some combination of delusions, hallucinations, disorganized speech and/or behaviors, and/or flattened affect or avolition), which usually leads to a clinical diagnosis of schizophrenia when other causes have been ruled-out (Schultz et al., 2007).

Schizophrenia is a problem of the young, having a prevalence of 1%, and typically affecting males in their late teens or early 20s, and females in their late 20s or early 30s (Schultz et al., 2007). It is considered, by contemporary standards, to be a polygenetic

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disorder having environmental and development causes that influence an individual's vulnerability to being diagnosed with schizophrenia (Lewis & Lieberman, 2000). Given its clinical heterogeneity, it is conceivable that schizophrenia more or less represents "a constellation of diseases that share some phenotypic features" and discriminating "among these possibilities will require the definitive identification of specific causal factor(s)" (Lewis & Lieberman, 2000, p. 326).

Based on my clinical experience spanning more than 15 years, the mainstay of treatment involves antipsychotic medication (can either be the older generation, and more commonly, the newer, atypical antipsychotic medications), often with combinations of other psychiatric medications (e.g., anxiolytics, hypnotics, mood stabilizers, and/or antidepressants) as well as some treatment focus on psychoeducation. Although many afflicted individuals experience symptomatic reductions (and possibly remissions) when treated early in the course of their illness, the majority of individuals go on and off their psychiatric medications, which is believed to be the most common explanation for frequent relapses and remissions following repeated treatment (Lewis & Lieberman, 2000). This is, unfortunately, associated with clinical deterioration and declining functionality over time (Lewis & Lieberman, 2000). It is really the destabilization resulting from abruptly discontinuing or quickly tapering a biologically habituated antipsychotic medication, and/or the resulting neuroplastic changes arising from the frequent use of antipsychotic medication (i.e., drug-generated buildup of supersensitive dopamine receptors) that is more likely to be responsible than are compliance issues for the chronicity of schizophrenia (e.g., Harrow & Jobe, 2013; Moncrieff, 2006).

As a result, most individuals with a diagnosis of schizophrenia are told (and sometimes forced) to remain on their psychiatric medications for life as a way to avoid this gradual and common deterioration that marks this devastating problem. Biomedical research has had a difficult time in figuring out "how a genetically mediated, neurodevelopmental disorder is not expressed clinically until 1.5–3 decades postnatally, but then proceeds to progressively disable its victims" (Lewis & Lieberman, 2000, p. 327). The prevailing theory that I slightly alluded to previously is that some interaction between vulnerable genes and early neurodevelopmental injuries eventually leads to malfunctioning connections between many different brain regions, which manifests or becomes unmasked by developmental processes (e.g., myelination, synaptic pruning, and hormonal changes) and stressors (Lewis & Lieberman, 2000).

Given that the causes of this heterogeneous syndrome are so varied, it is conceivable that in some (or many) cases, the complex reasons for its existence extend well beyond gene–environmental interactions within the context of a diathesis–stress milieu. An often ignored area of inquiry by biomedical researchers and/or biological psychiatrists involves an exploration of how existential crises relate to symptoms of psychosis, and how existential issues arising from the modern treatment of schizophrenia are likely to be involved in causing some (or the majority) of the long-term morbidity associated with the syndrome. By existential crises, I am referring to profound physical, emotional, and/or spiritual problems (Williams, 2012b) associated with "the ultimate concerns," such as "choice, responsibility, mortality, or purpose in life" (Yalom & Josselson, 2014, p. 266) that, when severely restricted, might be responsible for psychosis among some individuals, and often remain unresolved despite aggressive biomedical measures to calm the storms of psychosis.

In this article, I will describe some of the existentially oriented psychological models linking existential crises to symptoms of psychosis. Then, I will summarize qualitative

research demonstrating that the existential needs of many individuals diagnosed with schizophrenia remain ignored despite aggressive biomedical psychiatric treatment, and, as a result, often leads to existential oppression and ongoing infirmity.

EXISTENTIAL CRISES AND SYMPTOMS OF PSYCHOSIS

Although the dominant view of psychosis is biomedical, surely other possibilities exist because there is no accepted pathophysiological process that fully explains the syndrome of schizophrenia in a manner akin to organic diseases such as congestive heart failure, diabetes, and bacterial pneumonia. A plausible alternative view of psychosis holds that "psychosis may actually be the manifestation of a natural attempt of a psyche to survive and/or heal from an untenable situation or way of being" (Williams, 2012a, p. 28). In all the existential models of psychosis that I reviewed (see Williams, 2012b, pp. 117–133), it appears that there is some marked dialectical tension between anxiety related to death and anxiety related to life, which at some crisis point can no longer be tempered, and the individual becomes engulfed by so much anxiety that he or she loses a sense of self and manifests symptoms of psychosis. For example, Irvin Yalom (as described by Williams, 2012b) sees psychosis as arising from being utterly tormented by death anxiety, which is dealt with by clinging to the defense strategies of believing in one's specialness (i.e., that we are literally unbreakable) or believing in an ultimate rescuer (i.e., someone that we can literally fuse with to defy mortality, such as a God or someone believed to be supremely immortal). The net result is that individuals with psychosis regress and become very unstable because they cling to these defense strategies by swinging between extreme specialness (i.e., as manifested by feelings of omnipotence and/or compulsive heroic striving) and the ultimate rescuer (i.e., as manifested by merging with some "other" and losing all boundaries).

Rollo May, on the other hand (as described by Williams, 2012b) believed that a normal amount of anxious tension drives individuals and stems from the mere fact that we are mortal and will die at some point. If dealt with constructively, this normal anxiety does not interfere with life. If, on the other hand, the intrapsychic tension about death becomes overwhelming and cannot be dealt with constructively, then normal anxiety becomes neurotic anxiety. To quell this neurotic anxiety, an individual can individuate (i.e., to become more authentic and build a sense of agency), or an individual can become part of a community (i.e., to engender a sense of belongingness and to experience love). If an individual is too consumed by his or her independence, then hostility might arise from feelings of isolation compared to an individual who becomes too dependent on his or her community and then develops hostility from feeling suppressed. An individual might become psychotic when there are unsuccessful resolutions between the dialectical tensions of independence and dependence. When these tensions become unresolvable, some aspects of reality are sacrificed and symptoms of psychosis manifest.

Other, more modern existential theories have been published, which are similar to those proposed decades earlier, by clinicians such as Yalom and May. Fuchs (2013), for instance, speaks of "existential vulnerability" and how violating "limit situations" can bring about mental disorders, which would also include schizophrenia (p. 302). Limit situations are common for everyone (e.g., having to die, having to suffer, and having to fight) and can become highly distressful if they force an individual out of everyday experiences

into very distressing ones (e.g., experiences associated with trauma and medical illness). What essentially happens is that a limit situation becomes unresolvable by their suddenness or bleakness, and can lead to a "collapse of one's mental framework" (Fuchs, 2013, p. 304) and of one's self. Mental disorder (which would include psychosis, and therefore, schizophrenia) thus arises from "falling short of one's possibilities and of failing to realize one's possible *Existenz*" (Fuchs, 2013, p. 302).[2] Put more succinctly, Fuchs connects mental illnesses to limit situations, as expressed in the following passage:

> The deep felt impact that "yanks the carpet away from under one's feet" and that breaks down the "housing" around one's life plan can also shake the foundations of one's mental constitution to the extent that mental illnesses may result—especially when the limit situation as such remains uncomprehended and does not allow the person concerned any distance and freedom. (p. 303)

Like Yalom and May, the dialectical tension in Fuchs's (2013) model is between coping (i.e., living) and being near the limits of survival (i.e., similar to dying). Thus, when an individual's life or experiences exceed his or her capacity to contain limit situations, the self-preserving protections or buffers collapse and could very well result in the expression of psychosis.

In another modern model proposed by Kean (2009) that directly involves the experience of schizophrenia, an "existential permeability" persists when an individual becomes detached from himself or herself (because of overwhelming perceived stress) creating disturbances in "one's subjective self-experience and the external or objective reality" (p. 1034). In this model, there is a dialectical tension between the self and the world. If an individual spends too much time relating to the outside world, the result could be a loss of one's self by being "engulfed by others" (p. 1035). On the other hand, when an individual has no or only minimal connections to the outside world, then he or she may feel like imploding, like being destroyed from within. In either extreme, symptoms of schizophrenia manifest because the constant permeability between the self and world would lead to multiple realities and dissolution of the self.

All of the aforementioned models explain how psychosis could possibly erupt from unresolved existential crises that threaten an individual's sense of self. For the unfortunate individuals who experience these deep, extremely distressing and incomprehensible frightening experiences, the terrible truth is that their existential insults never get addressed or remedied in most cases. Instead of providing these individuals with intense psychosocial supports aimed at helping them work through their existential distress[3] (as manifested by psychoses), they are literally forced into the biomedical world of assuming the role of the "mentally ill" patient, and are usually coerced in some disguised "benevolent" manner into becoming lifetime consumers of powerful antipsychotic medications and other biomedical treatments.

My clinical experience has shown that almost all such diagnosed individuals are held at bay and diminished by the very antipsychotic medications given as solutions to their symptoms. These medications undermine an individual's intrinsic motivational system, reduce vitality, cloud and disable the brain, and make progressive and life-affirming changes extremely difficult to accomplish. Kean (2009) noted the following difficulties arising from the psychiatric treatment prescribed to her:

> The medication helps the observing self dominate over the suffering self, but the real "me" is not here anymore. I am disconnected, disintegrated, diminished. (p. 1034)

These, now "mental patients"—some (or many) of whom plausibly became psychotic from existential crises—are merely maintained in a lifelong holding pattern of inertia but with the additional pain and lifetime burden of acquiring a host of other unresolved (and unrequited) existential needs.

THE UNADDRESSED EXISTENTIAL NEEDS OF INDIVIDUALS DIAGNOSED WITH SCHIZOPHRENIA

Qualitative research has directly investigated existential issues among individuals diagnosed with schizophrenia, including what their caregivers report as well (e.g., Wagner & King, 2005, and Wagner, Torres-González, Geidel, & King, 2011).[4] With respect to the "need for personal development," which relates to the search for meaning in life, many individuals having schizophrenia are unable to find regular work because of their symptoms or stigma and often feel useless, unproductive, dependent, and even inferior to others (Wagner et al., 2011, p. 2). Moreover, many of these individuals feel a considerable amount of disillusionment by knowing that "all their childhood friends have an organized life, employment, a partner and children, while they have no significant accomplishments" (Wagner et al., 2011, p. 2). Without regular work, and by not having similar opportunities for "the good life" that other people without schizophrenia tend to experience, these individuals often succumb to an existence that lacks meaning and life purpose.

Individuals having schizophrenia also feel marginalized by the stigma of their illness. Biogenetic causal beliefs about schizophrenia are positively related to public prejudice, fear, and wanting to be distanced from such individuals (Read, Haslam, Sayce, & Davies, 2006). To make matters worse, it is common for them to be criticized for being lazy because of not having enough motivation, to be marginalized by family members (or even friends, acquaintances, or strangers), and to be seen as being potentially violent (Wagner et al., 2011). The stigma these individuals face is associated with much existential suffering because they are so often misunderstood, and the adversities they face are usually attributed to defects of character rather than being understood as part of the illness experience. They have a personal need to accept their own illness, but their self-acceptance is unduly challenged by the frequent rejections and harsh treatments they receive from others (Wagner & King, 2005).

The need for autonomy is an existential need related to independence and "not being subject to somebody else's will" (Wagner et al., 2011, p. 3). When symptomatic, these individuals are further constrained by their diminished cognitive capacity, which further encroaches on their need for autonomy (Wagner et al., 2011). Even when these individuals are asymptomatic, their autonomy is often diminished because of "the demands of treatment" (Wagner et al., 2011, p. 4), and by their own feelings of dependency and weakness (Wagner & King, 2005). Because of their diminished sense of freedom and ability to make their own decisions, other people often see such individuals from a dehumanized perspective—seeing only symptoms (Wagner & King, 2005; Wagner et al., 2011) and not recognizing that like all people (whether healthy or infirmed), these individuals want to receive care and attention that respects their humanity and empowers them to participate in their own decisions, especially when such decisions might significantly curtail their personal freedoms.

The "need for love" is another existential void that many of these individuals experience (Wagner & King, 2005, p. 143). They have difficulties expressing feelings and find that treatment has undermined their capacity to form intimate connections with friends or sexual partners. They also experience additional suffering because friends, family members, and partners "grow more distant" as a result of their illness (Wagner & King, 2005, p. 143).

CONCLUSIONS

I have attempted to demonstrate that some individuals might become psychotic because of existential crises in their lives. I have also attempted to show that once an individual with psychosis is given a diagnosis of schizophrenia, he or she has to deal with an additional host of existential issues, which more or less can be attributed to the following: (a) the biomedical treatment[5] provided, (b) how people view these "mentally ill" individuals, and (c) how these individuals view themselves.

It is abundantly clear that for these struggling individuals, treatment needs to involve the facilitation of unmet existential needs, for without such a focus, it is difficult to imagine how any of them will have the necessary motivations to get well. Every human being has a need for meaning, purpose, autonomy, love, and other aspects that facilitate personal growth or sustenance. If an individual is lacking in having his or her basic needs met (as is so often the case among individuals diagnosed with schizophrenia), then the craving for meaning becomes the most pressing need of all (Frankl, 1979).

NOTES

1. I do not recognize the validity of psychiatric labels/diagnoses or agree with concepts of brain disorder, psychiatric disorder, mental illness, and mental disease. All emotional processes are not discrete entities that can be cogently separated and categorized based on discrete signs and symptoms. Psychiatric disorders, mental illness, psychiatric syndromes, and so forth are not the same as bodily diseases that have fairly well-validated pathophysiological mechanisms. All emotional processes and responses arise from poorly understood and very complex heterogeneous phenomena. Thus, the uses of psychiatric labels, diagnoses, and/or disorders are themselves too simplistic in their conceptualization of any person's emotional problems or experiences. The only reason I use some of these terms throughout this article is because they have become standardized ways in which to conceptualize psychological distress.
2. The term *Existenz* represents "the being of a person at the limit" (Fuchs, 2013, p. 301).
3. There are alternative models of treatment that focus on meaning, choice, autonomy, and other existential elements. These models have been described elsewhere and use no antipsychotic medication, or minimally rely on such medication, compared to the contemporary treatment of schizophrenia. Often the outcomes are better with these alternative models of treatment. Some examples include Diabasis, Soteria House, and the Open-Dialogue approach used in Lapland, Finland. For a basic summary of these approaches, please refer to the following sources: Aaltonen, Seikkula, and Lehtinen (2011); Mosher (1999); Phillips, Lukoff, and Stone (2009); Seikkula, Alakare, and Aaltonen (2011); Williams (2012a); and Williams (2012b).
4. It should be noted that these findings are no different than themes of existential oppression that have been reported decades earlier. Mosher (1999) pointed out that individuals with schizophrenia who became completely enmeshed within the mental health system of their time

(i.e., "the institution") ended up being subsumed by living an institutionalized life. This dehumanizing existence happened by institutional forces that perpetuated "authoritarianism, the degradation ceremony, the induction and perpetuation of powerlessness, unnecessary dependency, labeling, and the primacy of institutional needs over those of the persons it was ostensibly there to serve—the patients" (Mosher, 1999, p. 3). Not much has changed at the present time, except that the emphasis on institutionalizing individuals has dramatically lessened since the early 1970s. It could be argued, however, that jails are fast becoming modern mental institutions of the present era.

5. One prominent study worth describing in greater detail included 64 patients with schizophrenia, 12 patients with schizophreniform, 81 other patients with psychosis, and 117 patients with no psychosis (Harrow, Grossman, Jobe, & Herbener, 2005). These patients were assessed as inpatients and then reassessed five times over the 15-year study period. At 15 years, the percentage of patients with schizophrenia in recovery while on antipsychotic medication was 5% compared to 40% of patients with schizophrenia who were not on antipsychotic medication for prolonged periods. In a more recent report by two of the original investigators (Harrow & Jobe, 2013), the patients with schizophrenia in their sample who were treated continuously with antipsychotics over 15- and 20-year periods showed considerable psychopathology and few sustained periods of recovery. They even noted that the sample of patients with schizophrenia who were not treated with medication for many years fared significantly better and had much better outcomes than the sample of patients with schizophrenia continuously on antipsychotic medication. They did not attribute these changes to better premorbid features or to favorable personality factors, such as having higher internal loci of control; rather, the prolonged and chronic course of schizophrenia was believed to be attributed to being more or less continuously exposed to antipsychotic medication.

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