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Multidimensional aspects of the life of subjects with psychosis - an existential study

Wielowymiarowe aspekty życia osób z psychozą - studium egzystencjalne

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Abstract: The presented paper attempts to outline the multidimensional universe of functioning of a person struggling with psychosis. The characteristic difficulties resulting from experiencing productive symptoms such as hallucinations, pseudo-hallucinations, parahallucinations and delusions are described together with the intrapsychic, religious, family-related and social aspects. Setting a specific type of psychotic disorders in the contemporary realities, the authors focused not only on the difficulties experienced by the patients, but also on the resources available to them.

Keywords: psychosis, social functioning, religiousness, coping, insight.

Abstrakt: W niniejszym artykule podjęta została próba zarysowania wielowymiarowego uniwersum funkcjonowania osoby zmagającej się z psychozą. Charakterystyczne trudności wynikające z doświadczania objawów wytwórczych w postaci omamów, pseudoahalucynacji, parahalucynacji i urojeń opisane zostały z uwzględnieniem aspektu intrapsychoicznego, religijnego, rodzinnego oraz społecznego. Osadzając specyficzny rys zaburzeń psychotycznych w realiach współczesności autorzy nie koncentrowali się jedynie na trudnościach, jakich doświadcza chory, ale także na dostępnych mu zasobach.

Słowa kluczowe: psychoza, funkcjonowanie społeczne, radzenie sobie,

Introduction

The so-called psychotic disorders, or psychoses are the most severe form of mental and behavioral disorders. They are characterized by the occurrence of productive symptoms, which include hallucinations, pseudo-hallucinations, parahallucinations and delusions. From the point of view of pathophysiology, psychosis is associated with hyperactivity of the dopaminergic system in the central nervous system. This is evidenced by the effectiveness of

neuroleptics (antipsychotics) in the treatment of psychosis. They are drugs that block the action of the dopaminergic system.

Psychotic disorders are usually equated with schizophrenia. However, it is not the only disease involving the occurrence of this type of disorders. Psychosis often accompanies dementia, abstinence syndromes (delirium), the use of some narcotic drugs, psychotic depression, mania and schizoaffective disorder. Schizophrenia is the most common, but not the only, form of psychotic disorders.

From the point of view of cognitive psychology, psychosis is the result of disorganization of the psyche caused by misprocessing of information by the mind. Own thoughts are perceived by the subject as external voices. The interpretation of the surrounding world takes place through the prism of delusions – the outside world becomes strange, threatening and alien. Losing the train of thought, racing thoughts impair (for an external observer) the logic of thinking, which further intensifies the sense of alienation. In extreme cases, the disorder of the course and content of thinking and the combination of words on the basis of sound similarity makes the speech of a person with psychosis incomprehensible and illogical to the environment.

In the society, psychosis is perceived as fearful, frightening and indirectly linked to the negative social picture of mental illness and psychiatry itself. It should be remembered, however, that significant disorganization of the psyche makes it impossible to plan an intentional criminal act. Therefore, the number of crimes committed by people with psychosis is ten times lower than in the healthy population. A person in psychosis, often looking dangerous, usually does not pose any danger to the environment. Unfortunately, the negative picture of psychosis prevailing in society is maintained by the mass media, which unjustifiably attribute psychotic disorders to various types of offenders. These criminals usually have an abnormal personality and are often influenced by addictive substances. However, that has nothing to do with psychotic disorders.

1. Personal, intrapsychic aspect of psychosis

Antoni Kępiński (1992) defines the essence of psychosis in intrapsychic terms as a break of the border between the inner world (“I”) and the outside world, which chaotically flood each other’s territories. Thus, the inner universe of subjects suffering from psychosis seems to be their objective reality, and the outside world seems to be their own world. The manifestations of such disintegration, which is an inconsistency of cognitive, emotional and motivational functions, appear to the person suffering as a sense of chaos and emptiness in the head.

Distortion of the individual way of experiencing one’s “Me” involves losing (nihilism) or exaggerating one’s own vitality (megalomania), decline (overpowering) or

overgrowth (omnipotence) of one's own actions, disintegration or idealization of the way of experiencing, blurring of the borders between oneself and the environment, and the loss or change of identity (Wciórka, 2017).

In the psychotic period, the patients find themselves in a completely alien and incomprehensible world, which is usually terrifying. This world is generally full of cameras, eavesdropping, reading in thoughts, overpowering by foreign forces, full of incomprehensible voices. This often leads the patients to try to take their own life. The suicide rate among people with chronic psychotic disorders is as high as 10% (Seligman, Walker, Rosenham, 2017).

Recovering from psychosis and regaining health makes the patients aware of their tragic situation. They begin to understand the strangeness of their experiences, which are often embarrassing for them. This fact exacerbates social isolation and significantly undermines self-esteem. For some patients, the extinction of psychotic disorders, which were the content of their life, leaves an existential void. Only psychosocial rehabilitation can, at least in part, fill this void.

The criticism of one's own psychosis is called insight in psychopathology. The patient's insight is always associated with suffering and fear that the disorder will recur again and that that individual is perceived as an "abnormal" person. Improvement, understood as awareness of the unreality of the world created by psychotic disorganization, occurs most often at the expense of mood quality, often leading to the development of depression (Seligman, Walker, Rosenham, 2017).

Patients with psychosis are often lonely. They do not have a partner, friends, or loved ones. The constant feeling of loneliness promotes the building of a negative self-image and a depressive image of the world in the process of salutogenesis. It makes a difference to recover with the support of the loved ones, whereas single people provided by social care with cold instrumental support come back to the mental norm in a different way.

The concept of social psychiatry presupposes the inclusion of people with mental disorders in the local social environment. Such inclusion, however, requires the creation of social economy entities in which sick people would be employed and would acquire the social competences typical of healthy people.

2. Spiritual/religious aspect

Among many patients suffering from psychotic disorders, faith in God or other forms of spiritual affirmation play a key role in the process of reconstructing the self-image, sense of meaning, and healing. Research indicates that even up to 91% of patients diagnosed with schizophrenia declare private religious or spiritual activities and 68% participate in public religious services or activities (Nolan et al., 2012). It has been assumed that the level of

religiosity in the population of people diagnosed with schizophrenia is higher than in the general population (Mohr et al., 2012).

Treatment of psychotic disorders is based on a biopsychosocial model that does not take into account the patients' beliefs in its design, although the World Health Organization considers human spirituality as an important area for assessing the quality of life (Culliford, 2002). Indeed, it appears that faith in God and spirituality in general can have a beneficial effect on the well-being of a person with psychosis, whose sense of identity and psychosocial functioning have been strained by the symptoms of the disease. Faith in God is a response to the constitutional need of every person to find the meaning of life and the value of borderline experiences. It brings spiritual reassurance and a sense of security in the face of uncertainty and evanescence, bringing hope to the sick and suffering (Wandrasz, 1998).

The religiosity of people with psychosis can be observed through two interlocking areas considered as a continuum: a complex of religious beliefs and religious hallucinations and delusions compatible with the religious denomination. There is a tendency to ignore and even completely pathologize the religious sphere of patients by mental health professionals, probably due to the presence of religious content in the productive psychotic symptoms (Lukoff, Lu, Turner, 1995; Crossley, 1995). Meanwhile, research indicates a strong link between the external and internal religiosity of a patient diagnosed with schizophrenia with the indicators such as the duration of treatment, number of hospitalizations (Tomczak, 2006), quality of life, level of psychosocial functioning, dependence on psychoactive substances, risk of suicide, or attitude towards pharmacotherapy (treatment adherence) (Mohr, Huguelet, 2004; Grover et al., 2014).

It is assumed that over 50% of patients diagnosed with schizophrenia construct a specific representation of the disease and the therapeutic process through the prism of religious beliefs. The experience of a psychotic state can be perceived by the patients i.a. as a part of God's plan, a gift from God, a test from God, or a punishment sent by God, a possession. It turns out that patients experiencing a psychotic crisis expect therapy compatible with their specific system of religious beliefs and the axiological universe. This sense of consistency becomes a significant predictor of the continuation of pharmacotherapy after hospitalization (Borras et al., 2007).

Caring for the adequate implementation of the spiritual needs of a person with psychosis can therefore result in both direct benefits for the therapeutic process and more favorable prognoses, as well as an improvement in psychosocial functioning and the overall quality of life of the person. The implications of religious involvement for the well-being of patients with psychosis can be seen in the form of the following mechanisms (Mohr, Huguelet, 2004):

- behavioral (e.g. habits associated with a healthy lifestyle);
- social (e.g. being a member of a community – support and a sense of belonging);

- psychological (e.g. faith in God, beliefs concerning life and death, ethical and axiological system, interpersonal relations);
- physiological (e.g. religious practices inducing a state of relaxation).

The key importance of the area of religiosity and spirituality for the quality of life of a person with psychosis is found in the notion of religious coping with the disease. One of the fundamental functions of religious beliefs in human life is its autotherapeutic character (Chlewiński, 1982). Experiencing a psychotic state and all its psychosocial consequences is undoubtedly a source of great stress for the patient. However, commitment to religious and spiritual beliefs and practices is considered one of the basic ways of dealing with stressors caused by the disease. Individual strategies in cognitive, behavioral, interpersonal and spiritual areas (Pargament, Ano, Wachholtz, 2005) can be classified as follows:

- search for the sense and meaning of the disease;
- seeking control over one's own life;
- seeking solace in closeness to God;
- seeking closeness with others and with God;
- seeking personal transformation/transformation of life (Pargament, Koenig, Perez, 2000).

It should be emphasized in particular that any strategy of religious coping with the experience of psychosis can take both positive and negative form, which is conditioned by the individual characteristics of the relationship with God. Research indicates that, depending on a specific sense of religiosity, the indicators determining health, psychosocial functioning and quality of life can be correlated either positively or negatively with the level of faith in God.

3. Family aspect

The systemic current of family therapy has developed on the basis of assumptions that schizophrenia is the result of abnormal messages issued in the family. An example was the so-called schizophrenogenic mother, meaning a cold woman, issuing messages of a double binding nature. The children of such mothers were allegedly suffering from schizophrenia. The symptoms of the disease became manifest in the weakest link in the family, and the disease was to perform a morphostatic function, that is, maintaining the family structure. Elimination of the disease would mean a breakdown of the family. Therefore, the condition for the existence of a family was the illness of its member.

Currently, systemic family therapy is far from such an extreme notion of schizophrenia in the family. Attention is drawn rather to the burden due to the presence of schizophrenia in the family. This burden is often associated with the need to care for the ill member until the end of the existence of the nuclear family. At the next stage, the burden is

carried by the siblings of sick people, who are taken care of by a brother or sister. The depth of changes in the family structure under the influence of the child's disease radically changes the ego inside the family, the identity, narrative, and affects the reformulation of transgenerational myths, which must take the disease into account. The illness of a family member is often treated as a punishment and misfortune. A positive reformulation is relatively rare.

Research indicates that a functional disturbance of the family system resulting from the onset of psychotic symptoms in one of its members affects the severity of psychotic symptoms and the degree of psychosocial disability of the sick person (Koutra et al., 2016). This triggers a hard-to-interrupt feedback mechanism.

Daniel R. Weinberger and Lipska (Papaleo, Lipska, Weinberger, 2012) discovered that the families of people with schizophrenia demonstrate numerous minor abnormalities in the performance of neuropsychological tests, typical of schizophrenia. This genetic marker of schizophrenia may affect the different functioning of families including people with psychosis, as already noted by the founders of systemic therapy. Modern social psychiatry draws attention to the devastating impact of one person's psychotic disorders on other family members and on building a positive image of a person with psychosis in his or her social environment.

4. Social aspect

Antoni Kępiński (1992) very aptly states that in psychosis social contacts usually described as "me-you" or "we-you" undergo atrophy to the of "me-he/she/them" formula, thus dismissing the possibility of achieving a common "we". In this extremely accurate view, one can see the essence of interpersonal difficulties experienced in psychosis. The fundamental difference between "you" and "he/she/them" is the understanding and human closeness, or a wall of solitude being built by their absence.

It would seem that this kind of distortion of interpersonal relationships, which are the foundation of social life, is directly caused by the specific symptoms of a psychotic state in the form of hallucinations and delusions. Psychotic disintegration, through the occurrence of irregularities at many different levels, i.a. thinking, speech, emotions, motivations, depletes the social competence of a person, thereby limiting the ability to deal with both simple and more complex social tasks (Wciórka, 2017). However, such a conclusion constitutes an oversimplification. While treatment with antipsychotics relatively effectively improves the patient's overall condition by eliminating psychotic symptoms, pharmacotherapy has a little effect on the improvement psychosocial functioning (McGorry et al., 2008).

It also appears that the onset of abnormalities in this area can be observed even before the onset of the first psychotic symptoms (Agerbo et al., 2004). The disturbance of the

premorbid trajectory of acquisition and implementation of social competences makes it significantly more difficult to form a sense of social identity, to build a social network, interpersonal relationships, learning pathways and professional career (Hafner, an der Heiden, 1999). Therefore, it often turns out, that the exit from the psychotic state becomes a way out into the social vacuum.

As a result of psychotic disintegration, the behavior and speech of a person struggling with psychosis becomes less and less understandable, inadequate and unpredictable for the environment. The bizarreness of clothing, non-compliance with hygienic rules, inappropriate behavior, speech resembling a "verbal salad" arouse concern among the public, leading to the formation of negative attitudes. On the other hand, for a person with psychosis, the social world becomes black and white: it is full of "angels and satans, extremely beautiful and extremely monstrous people, friends and fierce enemies" (Kępiński, 1992, p. 203). People waiting in a queue gossip about that person using a secret code, and neighbors lurk on his/her life.

A kind of weaning off from the daily chore around errands and duties, professional position, property and social aspirations is characteristic. The accent seems to be inverted, because while the society generally tends to look close and to the ground, people in psychosis see far away and "above the clouds". The immediate consequence of this kind of perspective is the far-reaching neglect of the issues of everyday life and of the social roles played, resulting in unemployment, homelessness, lack of social contacts, limited access to culture and entertainment, as well as rejection beyond the margins of the community (Zaluska, 2000).

Difficulties in social functioning should also be considered as a consequence of social stigmatization. Psychotic disorders, and schizophrenia in particular, which take on the social legacy of so-called "madness", are considered to be the most serious and at the same time the most stigmatized mental disorders. Numerous studies indicate that experiencing social stigma by people with psychosis can contribute to limited life chances, opportunities for personal development, poorer quality of life, decrease in self-assessment and self-efficacy, depressiveness, reluctance to cooperate in the therapy and, in extreme cases, even suicide (Świtaj et al., 2010).

Conclusion

Among all mental illnesses, psychotic disorders have retained the stigma of possession by arcane powers for the longest time. It was not until the second half of the 19th century that they were identified as a category of diseases, but today they are still surrounded by a nimbus of some kind of weirdness. In the archetypal image of "madness", long equated with psychosis, the specificity of intrapsychic experiences of the patients and

the range of introspection available to them is primarily fascinating. The break of the borderline between the outside world and the inner universe, on an equal footing with the social stigmatization of the patients, leads to specific difficulties in establishing and maintaining interpersonal relationships, and thus makes it significantly more difficult to achieve a satisfactory socio-economic status. The family relationships of the sick person are also tarnished. The system that the family undeniably constitutes is often overburdened with the necessity of providing support and care. The religious aspect of life of a person with psychosis is also extremely interesting. The religious beliefs, as well as active participation in the ordinances and life of the religious community, can be an invaluable source of support in dealing with the stressors, which the psychotic experiences and the acquisition of insight undoubtedly are.

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