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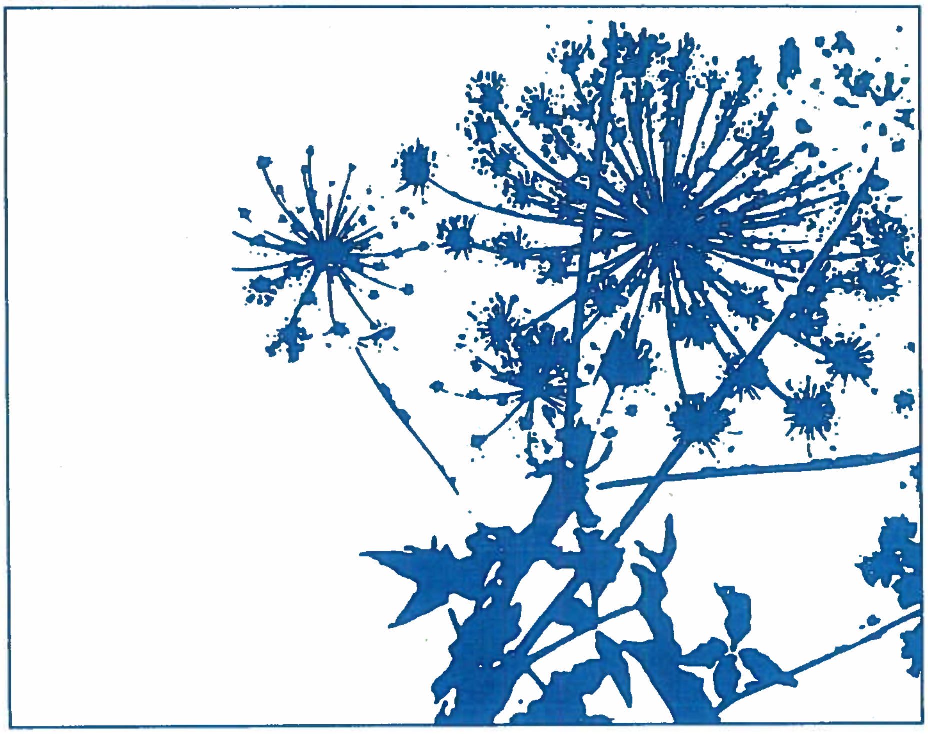

WITHDRAWAL AND EXCLUSION

A study of the spoken word as means of understanding schizophrenic patients

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To my children Helene and Einar Andreas

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TABLE OF CONTENTS

PREFACE

There are literally thousands of people living among us who suffer from chronic and severe mental illness. There may be as many as one out of 100 that might be described with the diagnosis of schizophrenia.[1] This means that most of us are likely to know, or know of, at least one person who suffers from schizophrenia. Nevertheless, most people perceive it as both distant and elusive.

The diagnostic description and characterization of Schizophrenia (DSM-IV, 1994:273ff; ICD-10, 1994:F20), says little about the experience of the illness or of the individuality of persons within the group (cf, Mishara, 1994). It says little concerning who the patients are as persons, what their lives are like and how they experience themselves and others.

It is easy to forget that schizophrenia is an illness that strikes individuals. The experience of schizophrenia thus will be unique for each person (Strauss, 1989; Strauss, 1996; Strauss, 1994). This study was triggered by the question of what is it like to experience a disorder like schizophrenia and the isolation that is associated with it.

The intention of this study is to describe some aspects of the condition and the suffering that schizophrenia represents. I was therefore granted access to a rehabilitation unit in a hospital in order to enter into dialogue with patients and staff about schizophrenia and the suffering involved. I also wanted to study how it manifests itself in everyday life.

Schizophrenia comes to expression in a diverse number of ways, but isolation stands out as fundamental to the way the problems and suffering are experienced. The explanations in the literature are primarily divided into two camps. The first sees withdrawal as a part of and/or cause of the illness. The patient withdraws because that is a part of the disorder (DSM-IV, 1994; Kringlen, 1982:310-3). The second group sees the isolation as an exclusion of the patient by

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[1] DSM-IV suggests a prevalence of 0.5%-1% (DSM-IV, 1994:282). It is estimated that 10 000 persons in Norway are diagnosed as having schizophrenia (Johannessen, 2002). Studies indicate some regional variation (Brown, 1994). Others raise the question whether prevalence is decreasing and outcome has become better (Harrison & Mason, 1993).

others. The exclusion may be explained as discrimination, intolerance for differences, fright, and uncertainty (Foucault, 1961; Goffman, 1969; Laing, Hogerzeil, & Ross-Degnan, 2001; Nasser, 1995; Szasz, 2001; Szasz, 1998; Isaac & Armat, 1990; cf, Wifstad, 1997:89-126). The views on causality are therefore in sharp contrast, even though both perspectives endorse the significance of the social aspects of the illness. This allows us to view the theories in relation to each other, and to ask whether it is possible to view withdrawal and exclusion as complementary aspects instead of being mutually excluding.

It is my concern to communicate a portion of the humane and experiential problems severe mental illness causes when we try to relate to persons suffering from schizophrenia and to take seriously both their words and actions. It is important for each of us to understand as fully as possible the world of the schizophrenic person and his or her individual life. It is also important that we gain an understanding of psychiatric rehabilitation as practiced and experienced in our society.

In order to be in a position to do that, it is necessary to look into how 'psychiatry' understands these phenomena. Psychiatry is a many-sided concept (Wifstad, 1998). Psychiatry as *'clinical praxis'* and psychiatry as *'medical speciality'* are of particular interest. Clinical praxis is a conglomerate of professions, and is performed within different institutions, type of treatment and health care. Psychiatry as a medical specialty is a form of knowledge that focuses on medical treatment.

On the one hand, it is a common claim that the expressions of psychosis are incomprehensible (cf, Gelder, Gath, & Mayou, 1996:9ff; Kringlen, 1982); on the other hand, we may ask whether there exists a genuine potential for understanding that is already present in clinical praxis. Staff members relate and respond to psychotic expressions all the time. This does not necessarily mean that these expressions are understood; however, it gives psychiatry the advantage of closeness to the people involved and offers a *potential* of understanding. The question is whether the view of what it means to understand another person is too narrow, thus making it impossible to actualise the potential that is already at hand within clinical praxis.

INTRODUCTION

1. FIRST IMPRESSIONS OF THE REHABILITATION UNIT

> I often think of those who are committed to long-term hospitalisation. They become almost like fish in an aquarium because people are constantly coming to observe them. Everyone sees them. They are aware that a great number of people pass by each day. When the observers go out, they can close the doors, get their own keys and pick up their own mail from the post office. There are plenty of things that serve to increase their dignity. That is more like what I connect with the notion of rehabilitation (Staff member).

1.1. Being a stranger

The people I met on the unit made a strong impression on me. I was a complete stranger there, and I felt like a stranger. This perception never left me throughout the entire time of the fieldwork. It had nothing to do with the reception I received. The management of the unit welcomed me. I was given keys as well as permission to come and go almost as I wished provided I notified them in advance.

My first visit took place two weeks before Christmas. It was twilight and freezing cold when I arrived at noon.[2] I had a lunch appointment with the management group on the unit in the 'main living room'. I was told that it was located on the unit. This lunch would then also mark the start of the fieldwork.

I found the main entrance, but it was locked. I went to the office block only to find yet another locked door. I then started to wander around the unit, hoping to find an open door, a doorbell, or simply to meet someone who could let me in. I found no one and it seemed almost as if there was nobody there. I circled the unit twice without seeing anyone either inside or outside. In the end, I noticed an anonymous door with a doorbell. I rang the bell and after a few minutes a young woman came hastily, almost leaping, towards the door and opened it. She had flour on her nose and was perhaps a few years younger than I. I said that I was looking for the chief psychiatrist. All she said was "OK" and then she returned as quickly as she had arrived. I entered and found her accompanied by two others in the main living room. They were occupied with

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[2] Due to the polar night the sun never rises above the horizon. It lasts from November 27th to January 16th.

baking gingersnaps. It was a relief finally to be inside; however, the frustration of almost not being able to find my way in underlined my self-perception of being a stranger.

The outer surroundings of the unit were well known to me. It was within walking distance from the city centre. The surroundings are scenic with mountains, many of which are 1000 meters high. On the other side of the unit, there is forest with trails for skiing and hiking.

The unit consists of several buildings. My impression was that they were not built with regard to aesthetics, but rather with regard to functionality. The unit consisted mainly of four blocks that were interconnected with corridors. The first tour of the facility was a rather confusing experience, despite the fact that the unit is relatively small. We walked up and down stairs, in and out of doors, and passed through corridors. I did not realise that I had lost all sense of directions until we suddenly passed a small courtyard and then to my surprise we found ourselves again in main living room.

Initially this gave me an impression of a maze. As such, it was a copy in miniature of the psychiatric hospital down the road. Nevertheless, it did not take long before I managed to orient myself in the facilities and understood when patients and staff referred to various parts of the building. The blocks and corridors were arranged at right angles to each other. Only the outer doors were locked, therefore one seldom ended in a dead end where one had to turn back. Some of the staff used the metaphor of a fortress: hard for outsiders to enter, and safe inside!

This was, however, not the case with the psychiatric hospital down the road. It consisted of a number of blocks, passages and corridors. It had a number of shortcuts that one learns little by little. I continued to feel that it is quite easy to get lost there. I do not normally find it problematic to find my way about, but I have tried to imagine what it must be like to be taken into this hospital when one is already afraid and confused because of psychosis or any other crises. Later, I learned that some of the patients did not even want to talk about these experiences, while others described their meeting with the hospital in terms of a sensation of fright and confusion.

1.2. Location and people

The particular unit on which I was to work was smaller than the hospital, and it took less time to establish an overview of the site. Almost the entire area belonged to the unit. One block consisted primarily of offices that were used by the staff. Two other blocks included apartments for the patients, while yet another consisted partially of apartments (the first floor) and partially of a shared area as well as the main living room (ground floor).

The shared domains were intended to serve as meeting places between patients and staff. They were arranged with two lounge suites, three dining tables and a kitchen, all in one large room. The unit was build to have a homelike and cosy atmosphere and yet fulfil the need for joint arrangements. The unit subscribed to several newspapers and they were very popular. There was also a television set. Although some of the patients had their own sets in their rooms, they sometimes came down to the main living room to watch their programs together. Two computers with Internet connections were also located there; however, staff normally used them for work related matters.

Generally, the activity in the main living room was completely informal, but on some occasions, joint activities like meals, workshops, or home cinema were arranged. The patients were encouraged to participate, although participation was voluntary. It was also expected by the management that the staff spend as much time as possible in the main living room. Patients frequently met their contact person there asking for help or advise. This could be with regard to medications, meals, the apartment, clothing, etc. If there was something practical, they usually went to the patient's private room. When the need involved something sensitive, they simply withdrew outside, to an office, or to a private apartment. Personal matters were also discussed in the shared areas when initiated by the patient.

The apartments were relatively small and typically consisted of a bedroom, bathroom, and a combined kitchen/living room. The apartments were fully furnished, which included refrigerator, sink, and electric stove. The patients were encouraged to decorate their rooms according to their liking, including their own furniture. However, they often did not have much furniture in their possession because some of the patients have lived in institutions most of their adult lives.

Some of the rooms have magnificent views. The main drawback is the closeness to the regional airport. Other rooms face inward toward the courtyard between the blocks. One of my contacts told me that he had chosen this type room because he liked to have the curtains drawn anyway.

The unit offered apartments in three different sizes and the patients were charged rent accordingly. A patient who was single usually got the smallest apartment, and the patients with family got the largest in order to accommodate family visits. However, if a patient had a reason for wanting a larger apartment, this could be arranged so long as one was available.

1.3. Monitoring and measures of precaution

Fire safety was a major concern when constructing the apartments. Smoke detectors were present everywhere and were part of a fire alarm system that was connected directly to the local fire station. One staff member explained this system to me, pointing out the importance of fire safety in places like this. A patient could be dull due to medications and thus hard to wake up in case of an emergency. It is therefore important to detect and locate problems as early as possible. The system exceeds the general public requirements for warning systems.

A staff member that stressed particularly safety issues gave me this orientation. I was informed about a fire at the psychiatric hospital a few years earlier. Life was lost in that accident and it was apparent that this was a dramatic event in many ways. The informant did not blame anyone at the hospital, but it showed how a fire in a psychiatric hospital causes unique problems.

When the hospital was evacuated, there were reports of patients wandering along the street, confused and far away from the hospital. It was impossible to maintain oversight over all the patients. My guide considered that an accurate warning system was essential in these institutions. It was also essential to have a clearly understood assembly point and regular exercises to make sure that both the staff and patients knew what to do in case of an evacuation. Only then would it be possible to establish who might be missing and hence conduct an effective search. He concluded, “Valuable time will be lost if you have to check every bedroom for patients.”

On the other hand, if the patients were to learn home economics they needed electric stoves. Due to medications, restlessness, and lack of concentration, it was not unlikely that they might fall asleep, or simply forget to turn off the heat or to watch boiling casseroles. To prevent fire, the stoves were connected to motion sensors that turn of the electricity automatically after they have not sensed any motion in the room for 10 minutes. From time to time, staff persons discovered stoves that were left alone. This would have been a dangerous situation without the system.

The staff member argued that this also had its disadvantages. First, it encouraged poor habits among the patients, because they did not have to be careful enough with the stoves due to the safety system. Second, the stoves were often needed for more than 10 minutes. If a patient sat down and waited, the system will shut itself off. The system then gave a warning beep. The resident had then just to wave an arm so that the sensor registered the movement and the stove would be switched on again. My guide demonstrated this by waving his arm. He said that he saw the irony in a rehabilitation program that aims to make the patients more 'normal', but which also included a system that may encourage strange and irresponsible behaviour among the patients. Nevertheless, he added, this is better than risking another fire.

The patients were closely followed up, both on formal as well as informal levels. Each patient had one primary contact person among the staff. This person was supposed to initiate co-operation with the patient with regard to how to fulfil the goals of rehabilitation. The staff member became a mediator and assistant in relation to family and public health services, as well as with local authorities. He/she also assisted with practical undertakings such as home economics, etc. As an inevitable consequence of this, the staff had full overview over almost every aspect of the patient's life.

The patients were also monitored with regard to their illnesses and their use of medications. Even though the levels of medications were supposed to be adjusted before they arrived, the chief psychiatrist admitted that this was seldom the case. Most of the patients could manage with smaller doses, which also would imply fewer side effects. They were therefore given close attention with regard to both symptoms of disease and symptoms of treatment.

The most extensive monitoring was probably done on an informal level, and was a result of the small size of the unit. For instance, it was not possible for a patient to sleep late without this being noticed. This behaviour was often accepted if the person did not miss appointments and it did not create major problems. For example, the patient could have experienced a difficult night. It was also common for a patient to be tired in the mornings due to medications. The point was that such behaviour was noticed, and when a patient had not been seen during the day, attention was called to this fact in order to investigate whether something was wrong.

Even though the regulations were more relaxed than at the psychiatric hospital, it was most likely impossible to avoid a degree of transparency at a small unit such as this. However, it was a concern to both staff and patients that, although they were free to come and go, they could not do so unnoticed. The system thus represented an unavoidable limitation of privacy. Staff members articulated this as a major concern. They thus tried to move with discretion. For instance, they never wanted to enter a private room without approval unless it had to be done in an emergency. These entrances had to be well founded and necessary and the reasons had to be explained to the patient afterwards. However, the patients often reacted with irritation and saw such entrances as an intrusion into their privacy. The need to be alone could also be in opposition to joint activities in which they were requested to participate.

Sometimes the need to be alone was understandable and acceptable, such as in the case of grief for a close relative. When the isolation continued over a longer period, the staff experienced a dilemma between an urge to do something and the need to respect privacy. When a patient locked himself up in his room, it would inevitable create a concern that the person might need assistance. It could therefore be difficult to determine whether or not to intervene.

1.4. Patients and staff

Both patients and staff expressed their feelings about the unit in positive terms. All of the patients had experiences with the psychiatric hospital, which resulted in their not wanting to return there unless it became necessary.

Many of the staff members, who had worked at the hospital, actually expressed the same concern. It was articulated as a criticism against a certain way of viewing the patients. The place was usually referred to as "back there" and in the past tense. I asked one employee whether he believed that they also were being rehabilitated as professionals and he responded:

> I actually believe that those of us who have been in this care-giving role and then get out are rehabilitated quite a bit, because we see that: Wow! This is just so much better. It is a much more decent way of relating to people.

Another staff member complained about how they cut themselves off from the patients back at the hospital. He thought that it was done in a manner that violated basic good manners. It seemed to be all pervasive. For instance, he said:

> A sign on one particular door read: "No admittance for patients". It was glaring, and put the patients in their place at the lowest rank. No other institutions use such vocabulary. You normally will not say something like this to people, but back there it is not even seen as a problem.

I suggested a more friendly limitation like "Staff only", which is seen elsewhere, but he did not really see the need to reserve certain areas just for staff. It represented aspects that were experienced as degrading for the patients.

The patients adjusted themselves and seemed resigned to the situation. When patients talked about these issues, they generally referred to particular situations in which they had reacted to the treatment with frustration or anger. However, the patients were in fact very cautious in criticising staff. This could have been due to uncertainty as to whether they could be overheard, or whether I might report their complaints to the persons involved, or again that the criticism could somehow come back to haunt them. They had also been in the system so long that they knew that there was always a possibility that they could be dependent upon the same person anew.

When patients and staff looked toward the future they also expressed a desire to remain on the unit. This was quite understandable from the staff's point of view. It was no wonder that they wanted to stay because they were happy with their work.

For the patients, on the other hand, the unit was supposed to be an interim home. The goal was ultimately to be able to live in their own apartment in their home community. The wish to stay on the unit articulated by patients also signified an expression of resignation. One of the patients said that he could not have had it better than he had it on the unit. He was concerned with moving out, because he needed support and assistance from staff all the time. On the unit, however, he had a place of his own and all the help he needed. He felt comfortable and did not want anything more for himself. Moving out did not represent a further step towards a goal. He feared relapse if he moved from the unit. Instead of moving forward, it could be the first step back to the hospital.

2. DEVELOPING A TOPIC AND PERSPECTIVE

This project was initiated when I, who have a philosophical background, was engaged at The Institute for Community Medicine in order to conduct a philosophical study of schizophrenic patients under rehabilitation. This established a bilateral co-operation that would bring about an *outsider's* perspective on psychiatry. The project offers clear advantages, but also difficulties of both methodological and ethical character.

2.1. Method

Philosophy of medicine is a careful and critical reflection on the scientific, ethical, and practical aspects of the philosophical presuppositions for treating disease and promoting health. The aim of this study is to give a clear understanding and presentation of these presuppositions. Furthermore, the project needed a clear foundation within the context of the experiences, concepts, and life world that it set out to describe. This was assured by the collaboration with patients and staff at a local rehabilitation unit. The point of departure and delimitation of this project is set in relation to this unit.

The situation at the rehabilitation unit was more settled as compared to what we could expect at a hospital or on acute units. The patients who lived there had lived through the initial crisis and were now trying to come to terms with their life. This implied a need to define what a normal life would mean in their situation, and how to achieve these goals. Moreover, most of the patients had long experience from different institutions before they came to the rehabilitation unit. The patients who lived at the unit suffered from different disorders, but only patients that have been diagnosed with schizophrenia have been included in the study.

The use of the term 'schizophrenia' in this context refers solely to the definitions found in DSM-IV. The diagnostic criteria for schizophrenia delimit particular settings in which it is correct to use the concept. The criteria are defined in terms of certain key features, where delusion and hallucinations, in addition to social and occupational dysfunction are essential features (DSM-IV, 1994:285). Schizophrenia is associated with little hope of total recovery; schizophrenic patients represent a group of patients who are far more isolated in comparison to other groups of patients (Garfinkel & Waring, 1981). This is the context for the treatment offered at the rehabilitation unit. Preparing for a life outside the institutions was not simply a question of battling the illness, but also an effort to come to terms and live with the symptoms of the illness and treatment. For many, this meant redefining the goals in life, as well as the quest to find out what living a normal life would imply for the individual.

The patients' life situation turned out to be an excellent basis for philosophical conversations. Many of them showed interest in philosophical, religious, political, and ethical questions. Even though the informants were recruited via the management of the unit, I had a clear impression that *they* chose *me* as a dialogue partner and not that I chose them. They were informed in advance that a philosopher was about to conduct a study at the unit; this resulted in curiosity and interest from the patients. When I started the fieldwork, they already knew about me. The contact continued for 18 months and included weekly visits. Out of the 12 patients on the unit, six gave their consent. One withdrew from the study after the first conversation. Six staff members gave their consent and participated in the dialogues. The number matches the number of patients that participated. If I had wanted more informants it would not have been possible to delimit the study to this unit.

The advantage with the small numbers of participants allowed for more time with each individual, and that meant better opportunities to approach the standpoint of the other. Since the aim is to look into the experience, that will always be individual and unique anyway, the low number of participants is also an advantage since it gives the opportunity to follow up the informants and get to know them better. It is not the intention of the study to contrast this group of patients to other groups of patients or schizophrenic patients in general. The small number of informants and the fact that they represent a homogenous group does not provide a broad basis for these kinds of comparisons. The general aspects are thus secured in the literature and publications whenever relevant. Sources of the general structures and information were secured from empirical studies, textbooks in psychiatry, interviews with staff members, DSM-IV, ICD-10, official reports and internal reports. These are used to describe a frame of reference to which the examples belong.

The contact with the rehabilitation unit is seen as the context for a philosophical dialogue. The interviews were qualitative, open, and explorative. Since the conversations were carried out at the unit, participant observation became a part of the experience. The most important scheme used was hermeneutical and argumentative.

The experiences from the fieldwork on the unit must account for themselves. The philosophical quest is to reflect on the examples offered. The reason for using *examples* is their particularity, which means that they allow the utilization of the details and uniqueness of each case. The disorder strikes individual persons and their social network. A scientific research cannot be allowed to lose sight of this, or else it will loose the uniqueness that is an essential part of any experience of being human.

The examples of most philosophical value are those that put our concepts, beliefs, and knowledge to the test. The small number of participants was favourable with regard to closer attention to the particularity, extraordinariness, and personal aspects of the experiences and narratives that have been the subject in this study.

A field journal was kept during the entire fieldwork. The experiences were recorded within 24 hour after each visit. Tape recorder was only used when possible. The main disadvantage with tape recordings was the hindrance it created during the conversations. I was dependent on a relationship of trust with the patients, and that which was said in confidentiality was not to be made liable to misuse. This was especially a concern when interviewing inhabitants. The use of tape recorder was often a problem and influenced on the information that were given. It was omitted whenever an informant did not like it or whenever they objected.

The material was condensed and organized by subject and discussed in relation to recognized philosophical concepts. The intention was to create a point of intersection between the examples of the fieldwork, the literature on schizophrenia, and the philosophical concepts. In order to achieve this, the project became an analysis of examples, rather than a traditional philosophical approach, which is conceptual analysis. This is justified because the meaning of the words is established in how they are part of the life world that they describe. Conceptual analysis must therefore turn the attention towards the practical horizon of the examples and discuss meaning within the context to which the concepts belong.

2.2. Ethical considerations

The work of the medical research ethics committees is based on international conventions such as the *Declaration of Helsinki* and *the Uniform Requirements for Manuscripts Submitted to*

Biomedical Journals published by The International Committee of Medical Journal Editors. This project has been assessed with no remarks by the Regional Committee for Medical Research Ethics (Cf, Appendix).

The contact with the patients and staff was organised through the chief psychiatrist. This was done in order to protect the anonymity of the subjects and make it easier for them to refuse participation. Participation in the study was voluntary and did not affect their treatment or relationship to the unit. They did not need to account for refusing to participate. I was only informed and given contact information about those who gave their consent. After their consent was available, I visited the unit and contacted the patients. All of the patients and staff were informed about my presence before my first visit.

Even when informed consent was established, it was a concern that the interviews took place on the unit that was the home/workplace of the participants. It was necessary to avoid invading their privacy. I soon discovered that the best procedure in gathering information was to sit down in the main living room in the unit and seize the opportunities as they came along. This offered a natural setting for the conversations in which the participants could maintain the initiative. Topics that the informants didn't want to discuss were avoided.

There was no problem in establishing contact and maintaining a constructive dialogue in this way. Most of the patients were curious about what I wanted from the visits on the unit, and what a philosopher might find out about them. Usually first contact was established by the question: "What is a philosopher doing here?" First, it meant an opportunity to clarify my role during the visits. Second, the question always resulted in different philosophical conversations. Specific questions about society, freedom, illness, and medication were usually raised early in the dialogue. They often had thought of questions they wanted to ask me during the next visit.

The patients, who had not given their consent, contacted me in this manner, too. I regard this as unproblematic and just part of good manners to engage in such conversations. It is perhaps unavoidable that these dialogues were a part of the general picture of both place and people, however no information from these conversations is included.

Anonymity was another concern. Information that could serve to identify the informants has been omitted. Information was omitted when it was too personal or was shared in confidentiality. Information that a patient had given would not be passed on to the staff, unless I had good reasons for doing so, such as imminent danger to life or health. This was however never required. Staff and patients could often utter diametrical opposite understanding of the same issues – for example concurrence regarding medications.

There is also a dilemma between *credibility* and the possibility of *backdoor identification.* This will be a problem no matter how large the study, because whenever information or opinions are recapitulated, a person who knows the patient or the informants themselves might be able to recognise it as something that this person might have said. This cannot be avoided unless its content is rewritten (distorted) to the unrecognisable, which would undermine the reason to conduct a field study in the first place. This might be acceptable as long as one recognises just what he or she already knew, and that there is no confirmation or denial as to which patients are involved. It is, however, necessary to avoid the possibility of concluding from one piece of information to the next. In addition, all names of people, institutions, and places are omitted. All information about age, address, or relatives is also omitted. I have included descriptions of physical appearances only when it is relevant to the discussion. Sometimes, when it is possible without altering the meaning, information is added or altered in order to misguide the reader with regard to identity.

Participants are divided into two groups. There were those who lived in the unit apartments and those who were employed. The latter group are referred to as staff (members) and/or personnel. The first group are referred to as inhabitants, but mainly as patients. This choice is problematic. The main objection is the stigmatisation that is associated with the term 'psychiatric patient', and for that reason the concept is often avoided. Being under rehabilitation also means that they have been discharged from hospital. Although 'patient' refers to more than hospitalisation, the term indicates another direction than the idea of rehabilitation.

Stigmatisation is an essential part of both withdrawal and exclusion that is the main problem discussed in this treatise. Furthermore, the participants themselves used different terms when referring to the inhabitants at the unit. The psychiatrist referred to the inhabitants as 'patients', other staff persons generally used the term inhabitants, and the inhabitants themselves often used the term 'patient' about themselves and others. Those who were closest to them (their neighbours) were referred to by name, and when they spoke about themselves in the past and in connection to hospitalisation and treatment, the term 'patient' was often used. Being an inhabitant covers most of the aspects of living at the unit, however being a patient was clearly one aspect of that.

2.3. Perspective

> Let us remember that there are certain criteria in a man's behaviour for the fact that he does not understand a word: that it means nothing to him, that he can do nothing with it. And criteria for his 'thinking he understands', attaching some meaning to the word, but not the right one. And, lastly, criteria for his understanding the word right. In the second case one might speak of a subjective understanding. And sounds which no one else understands but which I *'appear to understand'* might be called a 'private language'. (Wittgenstein, 1958b:§269)

The focus of this treatise is on the feelings of isolation or of being alone that many patients express and describe in relation to Schizophrenia. It is an extensive isolation that the patients experience; not only *from other people,* but it can also in a certain respect be seen as an isolation *from oneself and the possibility to understand oneself.* I have chosen to review the isolation from others in terms of two different movements or aspects, viz. Withdrawal and Exclusion. The intention is to see whether there is a way to penetrate this isolation and understand what the experience of schizophrenia is and what the patients try to express it. In order to do that, I want to review how the spoken word may serve as means to understanding the schizophrenic patient. This made it necessary to enter and participate within the context in which these words are expressed. This context was in a narrow sense the rehabilitation unit and in a wider sense 'psychiatry' as such.

Wittgenstein is important in this study, although this is not a treatise about Wittgenstein in the sense that it pledges itself to his texts as if they could offer a concluding solution for the questions raised by the patients in this context. The justification of using Wittgenstein is dependent on how his insights work in relation to the descriptions of the experiences in order to bring out a meaningful and illuminating perspective on these phenomena. My reasons for discussing *Withdrawal and Exclusion* in terms of *understanding* refers to Wittgenstein's own willingness to account for understanding in terms of human interaction (Wittgenstein, 1958b:§151). Understanding is not seen as an *inner* process (Ibid, §152-4). He furthermore relates the act of understanding closely to the grammar of "knows", "can", and "is able to do" (Ibid, §431; §150). Understanding is moreover related to the ability to account for oneself; however, every explanation that I can give myself can also be given to the other (Ibid, §209-10).

Without the possibility of *shared language*, the individual would have been isolated in a fundamental manner. Wittgenstein maintains that the concept of understanding represents various uses of the concept (Ibid, §526-7; §531-3). These various uses of understanding add up to its meaning and thus constitute his concept of understanding (Ibid, §532).

Hermeneutics is another philosophical perspective that is utilised in this book. Its use is solely justified in relation to the thematic. It thus represents an independent aspect, held together with the other major philosophical aspects, solely by the thematic. It is not fruitful to make a comparison of Wittgenstein and the hermeneutical tradition. Although this has been tried, there is a concern that the radical and distinctive character of both perspectives would be lost in such comparisons. Hermeneutics is however a comprehensive and perhaps even an all-embracing philosophical perspective. It is moreover natural to include hermeneutics on questions regarding fantasy, belief, and narratives.

A final question to answer is why the use of psychiatry in a philosophical investigation. The reason for describing schizophrenia and psychosis is that their expression takes the questions of rationality to its outer limits. It is perhaps the case that philosophy, possibly even in a stronger degree as compared to psychiatry, carries with it the perception that schizophrenia, or madness as it is usually called, is beyond understand or irrational. Sometimes madness is used not only in contrast to rationality, but also as a statement of what rationality is not; as if it is clear what madness, insanity, or craziness means. Another way of explaining the impossibility of understanding is to assume that the experience of psychosis represents an inner mental state of the patient.

The concept of psychosis is a crucial part of describing schizophrenia. Intelligibility thus becomes an issue related to schizophrenia as well (DSM-IV). Intelligibility can be directly attributed to expressions of psychosis in different manners. We either assume that its expression is incomprehensible *because* it is psychotic (causal explanation) or that we perceive the expression as psychotic *because* it is incomprehensible (grammatical explanation).

The situation at the rehabilitation unit was more settled and stable, as opposed to what we could expect at a unit that treats patients in a more acute phase. This allowed more time to inquire into the patients' perceptions. Consequently, other factors than intelligibility are brought forward as more typical of their problems, such as difficulties in achieving even moderate ambitions and goals, and problems coping with everyday matters.

Understanding the patient in the context of everyday life at the unit could sometimes be difficult, and yet, the suffering and the human aspects of psychosis were so obvious that it can hardly avoid being understood. It could be objected that the understanding is only superficial. It is possible to object and say that this only represents an emotional contact, or that this contact simply exemplifies how we might relate to other aspects than the psychosis. However, this misses the complexity of the situation and the interaction with the patients. It was not so difficult to understand *what* the patient said, but it could be difficult to comprehend *how* the patient could mean that which was said. The ambivalence opens to different problems. For instance, do we refer only to different uses of the concept of understanding? Have we reached a limit to what a person is able to express meaningfully? Is it possible to maintain ambivalence towards the patients' narratives?

Following the later Wittgenstein, we must resist the inclination to think that any experience (like those of psychosis for instance) exists as independent entities, and that language disposes more or less successful 'tools' to describe this entity. The private language arguments of Wittgenstein aim at bringing to light a misunderstanding of language in which privacy, inner states, and even how words assume meaning become problematic. The private language or private objects are, in this connection, meant as a logical construction that is used to portray the language and how words appropriate meaning. The private language is introduced in this book as a perspective in which it is possible to review psychotic expressions as compared to other expressions, as well as looking into how a so-called 'psychotic language' may assume meaning. The question is whether it is language, and not the experience as such, that constitutes the shared ground on which we relate to the experiences of the other.

This leads to the crucial point about language, viz. *the possibility and necessity of a shared language.* The focus on everyday language was given due to the practical and trivial nature of the rehabilitation program. The everyday language is connected to the way humans interact in surroundings with which we are familiar. Philosophy traditionally describes everyday language in negative terms and in opposition to a technical, unambiguous, scientific language. Wittgenstein confronted this view in his later work, and announced a return to everyday language (Wittgenstein, 1958b:§71). Language must presuppose the kind of flexibility that is part of everyday language. It implies that the meaning of words cannot solely depend on unambiguous definitions to eliminate error or misunderstanding. The manner in which words are actually used and are connected to life becomes crucial.

How does the concept of understanding elucidate the problems of withdrawal and exclusion? If we do not share a language in which to describe the experiences of schizophrenia, does this signify a fundamental isolation? The clue will therefore be to take what we seem to understand, the trivial setting, as a point of departure. Then we must ask whether it represents more than superficial understanding, and how we relate to inner experience in general.

The concept of illness is a problem when evaluating psychotic expressions, not in opposition to, but in terms of 'ordinary' expressions. Although this perspective does not necessarily imply that understanding is simple (or even possible), it is necessary to maintain a concept of illness independent of the question of intelligibility.

As long as the academic tradition, in which psychiatry as a speciality belongs, maintains a too limiting conception of language and inner states, understanding the psychotic patient seems absolutely excluded. However, the term 'psychiatry' refers to more than just a medical and research speciality, it may also denote the praxis and an extensive conglomerate of many different professions and services that aim at treating the patients (Wifstad, 1998). When one thus enters the narrative situation of the clinical praxis, it reveals a discrepancy between what *is done* and what psychiatry as a speciality *says that it does*. The intention is to look into a potential in the clinical practice that is already present, but that is made complicated or even hindered by a misunderstanding of what it means to understand the other. This misunderstanding is maintained by a certain perception of language and a concept of inner states.

The treatise is written as an essay with narrative elements. This is done in order to relate the experiences from the fieldwork with the philosophical discussion. Although the narratives represent the basis of the discussion, most of the text is comprised of reflections over the narratives. The choice of genre makes it possible to connect the philosophical and medical literature with the experiences and narratives based on the fieldwork. It also makes it possible to develop an argument on the succession of the different aspects of withdrawal and exclusion.

3. EXPERIENCES OF BEING ILL AND THE PROBLEM OF PRIVACY

Withdrawal, asocial behaviour, and problems of a social character are listed as characteristics of schizophrenia (DSM-IV). Withdrawal represents a problem of the illness that is especially relevant for understanding the first hand experiences. Withdrawal, in the sense that the patients do not *want* to speak of illness or their life situation, is a possibility. There is also the possibility that there are aspects of the illness that *cannot* be told, not because they don't know, but because they lack the words to express it. The reluctance to speak is a matter of trust; lacking the ability to speak is of philosophical significance as it indicates a limit to what we are able to say.

The question is *how* we understand or *how far* the understanding can take us in seeing what the other means. This does not presuppose that psychosis, as the main characteristic of schizophrenia, can be understood. The answer to the 'how far' can be 'not far' or 'nowhere'. The issue, therefore, is whether we may have access to understanding schizophrenia as an illness. Do its expressions offer access to what it must be like? What does it say about the person him or herself? I have chosen to discuss three examples in the following text: anxiety, identity, and hallucination. The primary question is how inner states and properties come to outer expressions and thus become part of a shared language. The subsequent question is whether we need this kind of knowledge about the other person.

3.1. Anxiety and everyday life

Anxiety will be part of any description of life at the rehabilitation unit. Even though anxiety was an everyday matter for many of the patients, there is nothing trivial about it. The anxiety could be related to specific objects or situations. Patients emphasised problems especially related to social settings. At other times, anxiety could be an undefined, eerie, and overwhelming sensation that was hard for the patient to articulate or explain.

Anxiety represented perhaps the most severe suffering that was expressed during the fieldwork, and it interfered with most life situations. The atmosphere of anxiety was seen as invasive and all consuming. It could dominate the entire life of the person. For instance, if the patient had a constant fear that someone wanted to get rid of him or her, this will characterize every relation to other people. It could also express itself in the suspicion that the room was bugged, and that someone was listening, or simply waited for the right opportunity to get them.

The patients used many different strategies to cope with their anxiety. Medication was one strategy. The staff members were restrictive in the use of medications because they can be addictive and merely serve as treatment of symptoms. It was still seen as a necessary step to take in order to dampen anxiety. Sometimes patients begged the staff for medicine to allay anxiety. It must have given short-term relief even though it did not solve the problem. One patient indicated that the medication only made him forget, and he perceived this 'forgetting' as an additional problem. He could not live without the medications, and he had difficulties living with them.

The patients also had other ways of dealing with the anxiety. One could withdraw to a room and be alone. Another informant explained the need to have someone whom he could trust available all the time. The other person did not have to be physically in the room, but he had to know that he/she could be reached if it became necessary. Eating was described as relieving. Drinking alcohol was described as helpful, although it could make one feel worse later on. Talking with oneself was also described as giving relief. One person indicated that he experienced comfort through prayer, especially if he knew that someone else prayed for him.

One coping strategy was simply to try to avoid situations one associated with anxiety. Anxiety was, consequently, an obstacle in everyday life. Even doing simple things that normally are taken for granted, could create overwhelming problems for the patients. One patient explained how she finally had managed to get on the bus; however, she had had to leave the bus after a couple of stops because the anxiety became too severe. I asked what made her so fearful, and she said "social anxiety". It was simply a matter being too close to strangers. Still, she regarded it as progress that she dared to enter the bus at all. I can also imagine that using a technical term like 'social anxiety' also serves to keep it at a distance.

Staff had a lot of sympathy with the patients. This sympathy was mainly based on the terrors of the patients' experiences and their difficulty in dealing with everyday matters. Rehabilitation was a very *concrete* form of treatment. It was a supplement to the medical treatment and consisted mainly in training and habituation to an independent life. The focus was, therefore, on everyday life, and the expression of the illness falls within day-to-day life as a question of how to deal with its problems.

3.2. Hearing voices and speaking about them

Does it make sense when patients speak of hallucinations? Does referring to such experiences inevitably collapse into a private language because it refers to inner states and experiences? Hearing voices was clearly difficult for the patients to discuss:

> The first period after I was there [that is at the psychiatric hospital], so many strange things happened to me. People went in and out of my room all the time. It was especially … one elderly woman … in and … looked angry on me … sharp face. *They told me that it was only the psychosis, but I am not sure because it was all too real.* (Patient)

This patient spoke of experiences that happened during hospitalisation several years earlier. The speech was interrupted; he paused and was often in search of the right words. The staccato of what he said in this quotation and in the rest of the conversation, stood together both as interrelated and independent expressions of the experiences.

In one way, the sense of reality and his understanding of the experiences slip out of his grasp. He is not *sure* what is true and what is only a product of his imagination, which manifests a certain insight into his illness. It was obviously difficult for him to distinguish between the real and the psychosis because the respective experiences resemble each other. For instance, how do you feel the difference between a real and a hallucinated pain?

One informant spoke of sleeplessness and tiredness in the following manner.

Patient: Do you believe in ghosts?

I: I have never experienced anything like it. Do you believe in ghosts? (Thinking, of course, I don't, but here comes something)

P: I often wake up at night, and there are spirits of dead people in the room. It is dark. I cannot see anything but they speak to me.

I: What do they say? (Thinking: hallucinations/voices)

P: Different things! They ask me questions, difficult questions. Questions I do not know the answers to.

I: What do they ask you?

P: I do not want to say that, it is too personal.

I: Where do they come from?

P: The cemetery, I guess.

I: Do you know them?

P: It is the same spirits, sometimes others.

I: Did you know any of them when they were alive?

P: No, don't know. I don't recognize them like that.

(Pause)

I: It must be very frightening. (Thinking: I guess I would have been scared waking up at night and the room was full of dead people's spirits)

P: No, it is just strange.

I: How is that? Is it because it is ghosts?

P: No, it is strange that they show up at my room.

I: How is that?

P: Well, they are dead and can most likely go anywhere they want. Why do they wake me up? … I do not know the answers. Why don't they go to somebody where they might expect to get the answers?

Two aspects are revealing about his experiences. First, is the fact that he actually can hear voices that are so clear that he can understand what they say; second, is his own relationship to these voices and his astonishment at being selected by them.

Wittgenstein discusses the language of sensation and uses a variety of examples, like seeing colour, speaking about sensations, and feeling pain. How may I refer to an inner sensation like pain without depending on a private definition? Doesn't it presuppose omniscience for others to see that to which we refer? The question is even more to the point when we look at the situation of referring to hallucinations. Patients actually speak of the voices they can hear in different manners. The question of *what* the voices are can be left undecided by the patient, although ideas were also connected with the voices to explain these sensations. Voices may be characterised with explanatory metaphors such as 'radio receivers', 'telepathy', or 'persons present'. Patients offered occasionally direct accounts by recapitulating or quoting what they have heard.

Even if a hallucination doesn't have outer causes, it is still a *sensation.* You see, hear, and feel although what you see, hear, or feel is not there. How can other people relate to such experiences? Do we need to perceive or share the experience of the hallucination in order to understand what is meant? Do we need similar experiences in order to have a frame of reference and what would this shared context be? The private language arguments do not offer a solution to these questions other than an assumption that certain questions will remain unanswered. Instead of solving this dilemma, Wittgenstein suggests that these considerations do not play any part whatsoever in the act of understanding inner states.

> Suppose everyone had a box with something in it: we call it a 'beetle'. No one can look into anyone else's box, and everyone says he knows what a beetle is only by looking at *his* beetle. Here it would be quite possible for everyone to have something different in his box. One might even

> imagine such a thing constantly changing. - But suppose the word 'beetle' had a use in these people's language? –If so it would not be used as the name of a thing. The thing in the box has no place in the language-game at all; not even as a something for the box might even be empty. –No, one can 'divide through' by the thing in the box; it cancels out, whatever it is.
>
> That is to say: if we construe the grammar of the expression of sensation on the model of 'object and designation' the object drops out of consideration as irrelevant. (Wittgenstein, 1958b:§293)

If speaking of inner states were based on this kind of grammar, we could assume that we meant the same; however, there would be no way to reveal a possible misunderstanding.

What is a psychotic expression then? It could be regarded as a feature that has its ground in whatever causes the psychosis. Kringlen (1990) reckons expressions such as 'My head is growing' or 'My genitals are shrinking' to be typical examples of psychotic ideas which he sees as false beliefs, meaning that they are not rooted in reality, but in some disturbance of the patient's brain. The expression is consequently meaningless, and it cannot be understood other than as a symptom or sign of a disturbance. Hence, the primary meaning of these expressions is 'outer', that is a visible sign for something else. The meaning of *what* is said is more questionable. If a person cannot distinguish between what is real and what is unreal, how do you know that the explanation given to ideas has anything to do with the reality?

However, why doesn't it make any difference *what* the person says, apart from being a symptom? Is it of no significance that the patient quoted above reports hearing *ghosts?* The most interesting part is even omitted, viz. *what* they actually ask him. Moreover, what he actually says about his own relationship to the *ghosts* is interesting. What they say is indeed very personal. Kringlen is correct in his assumption that we do not need these kinds of differentiations in order to perceive them as a symptom (of, for instance, schizophrenia). However, the criteria of the illness are not in question here. The issue is what these narratives say about the narrator and what they say about the experience of being ill and his subjective experience of his life situation. Even strange and impossible ideas may communicate serious concerns that may be difficult or even impossible to phrase otherwise. How am I to relate to such a story? Is the outer expression of the experience of hearing voices sufficient to reveal an inner state or perception?

3.3. Sharing inner experiences by outer expressions

The easiest way to make me understand would be to *show* me. A teacher once *showed* me a singing nightingale by taking me to the place where he had heard it the night before. Standing there listening to that bird, for the first time in life, I could understand what the song of the nightingale was like. The song of the nightingale is, of course, beyond description. All we could say was 'Isn't it beautiful?'

Let us imagine that I stayed all night listening for the voices that the patient reported. There is no way the patient could show me the voices of the dead people that he heard. However, what difference would it make that I (most likely) would not hear anything? Let us say that he woke up and said: "There they are, now they are talking to me" and I still could not hear anything. Perhaps it could be said of me that I do not have the gift to hear spirits, yet another explanation could be that this is a hallucination and a figment of his imagination. The experience of being there when it happened does not add anything new to the description.

It is not necessary to question the experience as such, even if he experienced that someone was speaking in the room when nobody was present. What kind of concepts could possibly describe the experience of having the spirits of dead people in the room talking to you? The use of the concept "psychosis" defines one possible context in which to deal with these kinds of stories. This does not regard the description as solely an inner state, but rather the outer expression of it. As one psychiatrist told me his point of view:

> Psychiatry is the only human science that actually has taken the consequence of the impossibility of understanding what others actually mean. Instead of trying to understand, we describe the behaviour.

Even though his formulation is controversial, it is interesting that the main statistical and classification manual describes schizophrenia based on what you can actually see and hear (Mishara, 1994). It is not completely clear what the 'outer' expressions signify, or why it is seen as advantageous to evade the question of what is going on in the patient.

A hallucination is a sensuous experience without outer causes. It is private in the sense that nobody else has the same impression. It is a sensuous impression that cannot be shared *as* a sensuous impression. The only thing the clinician can see and hear is that the patient reports hearing voices. This does not imply that access to the inner state is impossible. In fact, the way we speak of hallucinations indicates the contrary position, viz. a direct access to the patient.

During a clinical presentation, a psychiatrist commented the following concerning a patient that formerly had reported voices:

> She reported hearing voices when admitted and the following month at the hospital. She *denies* today that she has heard them since that. It could be due to the effects of medications, or she does not want to tell us about it.

The statement that the patient perhaps *denies* hearing voices is interesting. The patient says she does not hear voices, and yet the psychiatrist thinks that she does, even though there is no way he can know. He knows of course that the patient may have reasons to *hide* symptoms of psychosis from him, perhaps in an effort to be reported fit enough to be discharged from the hospital.

Even if reporting voices is solely outer expressions of inner experiences, to claim that psychiatry must limit their reports to what we see and hear is problematic. How is it possible to suspect that the patient lies about hearing voices? What we hear is one patient who says that he can hear ghosts and another that says that she cannot hear anything. However, can we take this as a meaningful report if we do not assume an inner experience that accompanies the expressions?

If we disregard the significance of the inner experience all together, it would be valid as criterion for psychosis every time anybody claimed to hear voices that nobody else could hear. In that case, there would be no grounds for suspecting that the patient was withholding something. Moreover, if there is no shared ground for this expression, you cannot know what it means, and using it as a criterion to recognise psychosis would be pointless. This would be equally absurd. Then again, the problem of reporting hallucinations is one that belongs within interpersonal interaction.

Patient (Coming into the room from the bathroom): Did you talk to someone?
I: No, nobody is here.
P: You didn't use the phone or anything?
I: No, why?
P: I thought I heard something.

One person heard something; I did not. The problem of inner experience is still not overcome. I did not see what is going on in him, or did I? He could of course engage me in this conversation as a kind of a joke. Alternatively, I could actually hear something, but say I did not as a morbid attempt to make him believe that he was hallucinating. Unethical, for sure, but still possible!

Either way, we cannot evade the question of inner experience; otherwise, concepts like hallucinations and psychosis would be void of meaning. The game of registering certain sensations, like hearing voices, is both specific and possible. However, as long as it is seen as just a mere registering of an inner feeling, it would only be an example of private ostensive definitions. The technical language that we use to differentiate and categorise those sensations could be both specific and concrete, and yet they are referring to inner experiences. Moreover, as private definition, uttering them would not make any difference. There would be no way to know what they refer to, even if they are used correctly and truthfully. There would be no way to know whether my associations to the reports correspond in any way to what he meant.

The first reaction, when hearing about the ghosts, was to suggest unease or fear of the spirits. He dismissed this, claiming that he only felt astonished. I cannot assume that I have any corresponding experiences of my own. Moreover, when we raise the question of delusion, how can we assume that we share a grammar and logic to talk about such events? Instead of trying to understand the impossible, we restrict ourselves to a description of what we can see.

Psychotic experiences, as inner experiences, seem to deny others access to them, thus making it impossible for others to comprehend what the patient is talking about. The objection that we cannot see what's going on in another person, will be true for any concept describing a sensation and perhaps for any concept at all. This is, so to speak, based on an impossible criterion for understanding, as if understanding another person must involve *being* that person, or reading the mind of the other. The crucial point regarding psychosis is that it is more obvious that we do not see what is going on, so the possibility that we do not understand is obvious.

3.4. Knowing and saying

Wittgenstein points out that there is a difference between *knowing* and *saying*:

> How many feet high Mont Blanc is –
> how the word 'game' is used –
> how a clarinet sounds – (Wittgenstein, 1958b:§78)

It would be peculiar to claim that one knows but is not able to say in the first instance, but it certainly would not be peculiar in the third instance. There is a difference between what a person *wants* to say and what a person *is able* to express. The problem is thus not limited to extraordinary experiences like psychosis. The problem is far too trivial for that. Even ordinary experiences may be difficult to articulate clearly. How would you for instance answer the question: "What does coffee taste like?" We seem to lack words to describe it properly.

> "One can't describe the aroma of coffee." But couldn't one imagine being able to do so? And *what* does one have to imagine for this? If someone says: "One can't describe the aroma." One may ask him: "What *means* of description do you want to use? What *elements?" (Wittgenstein, 1980:104)*

A description of taste is not like describing a geometrical figure, or giving someone directions in the city. I could try to solve the problem by being poetical and use metaphors or similes: "Coffee tastes like…" It may work if we have something known to which we can compare. "A lime tastes like lemon only more bitter." Perhaps I cannot think of anything that resembles coffee: "Coffee tastes like nothing you have ever tasted before."

However, even the best descriptions could not reproduce the actual taste of coffee, and yet, that is no problem. If I wanted to do that, I would simply give you a cup of coffee and say, "*This* is the taste of coffee!" It suggests an ostensive definition in the sense that I direct your attention towards a particular sensation. However, what am I pointing to? – It is not pointing in an ordinary way, but what I try to do is to direct your attention towards the sensation that coffee arouses while tasting it.

How do I know that what you taste equals what I taste? It seems like I am referring to the sensation that the coffee arouses in me, and then I could compare that sensation with yours. These sensations remain inner, private feelings. Something about referring to sensations intuitively suggests that we use *private* ostensive definitions of meaning. In that case, how do we manage to talk about experiences we do not have in common, where no 'showing' or 'comparison' is imaginable?

How would I go about describing what milk looks like to a child who is born blind? "Milk is white", I could claim this, but what is white? I could go on explaining: "The whitest things I can think of is newly fallen snow in the winter, or the neck of a swan." The child could feel the snow, and I could use my arm to resemble the neck of the swan. The child could feel it. Most likely, this would not teach him or her anything about the appearance of milk. The child cannot feel the arm and say: "Now I know what milk looks like."

Consider the experience of psychosis: How can a person describe what psychosis feels like? If you regard the taste of coffee as inner experience, the situation of psychosis seems even more private. You hear people talking, but no one is there when you feel your mind influenced by unexplainable forces. You experience the pain of electric currents running through your body, but there actually is no current. No one is present when there is disorientation, anxiety, or suspicion, and so on. Nor is it possible to *show* what you mean in relation to taste or sense impression. How can one evade the problem of entering a private language when your speech refers to the type experiences that psychosis represents?

However, what is difficult to understand about these expressions of psychosis? Isn't it possible to say that speaking of the sensation of electric currents or fear, and of hearing voices represents understandable descriptions of what it must be like? Even though we do not share the experience, as experience, we share the language in which the experience comes to expression. The question is whether we need a concept of the inner that goes further than this. The objection might be that it only allows a superficial knowledge of the other. In the following chapters, we will look into the context and interaction with the patients in order to discuss whether their expression represents an adequate access to the experience of the other.

PART I:

REHABILITATION AND EVERYDAY EXPERIENCE

Why are psychiatric institutions being downsized? A possible answer is that psychiatry has become increasingly medical in its orientation. We think of psychiatry in terms of hospital treatment and not 'asylum'. The hospital is a place we go to for treatment. When treatment is completed, we return home as soon as possible. Another aspect is the political demands for efficiency that modern institutions face, which entails an *empirical* demand for *documented effective treatment*, and the economical equivalent seen in some articles: *cost effective treatment.* Sue E. Estroff has been concerned with this area within the context of American society. The general discussion on the use of institutions, community training and rehabilitation is however relevant in the local context of study. The debate on what is appropriate treatment is particularly interesting even though the Norwegian context and society is different as compared to the American society. It may be true that the deinstitutionalisation movement initially was driven by ideological reasons. Deinstitutionalisation, in this context, is understood as "an integrated set of social policies designed to promote a reasonable level of functioning among the handicapped with the fewest possible restrictions on their mobility and social participation" (Mechanic, 1978:3). Mechanic argues, furthermore, that the deinstitutionalisation movement represents a reaction against the abuses and inefficiency of the institutions and a desire to change the treatment regime and service *within* mental health service.

When studies indicated a better outcome among *discharged* schizophrenic patients, it offered an empirical basis for a movement that offered an opportunity to substantiate it in 'medical' and empirical terms. Even though poorer outcome is expected in cases of schizophrenia as compared to other mental illness, deinstitutionalisation is expected to offer better quality of life for these patients: better outcome (Priebe, Hoffmann, Isermann, & Kaiser, 2002).

Ideological questions are not absent today, but seem secondary, although establishing empirical material is not a neutral activity since such research may support or reject these values. The ideological questions are in fact controversial; however, for that reason it is important that they do not remain a hidden agenda in an ongoing debate.

4.1. Deinstitutionalisation and the problem of exclusion

Deinstitutionalisation must not be confused with the anti-psychiatric movement. While the anti-psychiatry movement rejects the fundamental conception and way of treating people as ill, the deinstitutionalisation movement signifies a regime of treatment *within* psychiatry. Deinstitutionalisation is based on ethical as well as empirical arguments.

Deinstitutionalisation is relevant for rehabilitation for at least three reasons. First, the goal with psychiatric rehabilitation is to make people as independent of the institutions as possible. Its purpose thus concurs with the main idea of *deinstitutionalisation.* Second, when staff members talked about treatment and how their rehabilitation unit differs from other services in the region, they referred to moments that are emphasised as key features for the deinstitutionalisation movement. Third, the problems the patients describe with society, hospital and institutions concur with a problem horizon described in the deinstitutionalisation movement.

Sue E Estroff has been involved in describing the expressions of patients' first hand experiences. Her main contribution concerns how the structure of the institutions also manifests itself outside the institutions. She thinks we have seen a change since the early days of deinstitutionalisation, but maintains that the main problems connected to treatment and the social structures of institutions remain unaltered (Estroff, 1981; Estroff, 2001b; Estroff, 2001a). Estroff places herself within the conceptual framework of Foucault and Goffman and the criticism of institutionalism they expressed. She evaluates community training and rehabilitation in these terms and argues that it doesn't necessarily represent *de*institutionalisation, but may simply manifest the institutionalism outside the walls of the hospital.

Foucault explains the establishment of the asylum as a disciplining strategy and an intended exclusion of the "madman". Madness reveals aspects of life that are unbearable to us. The asylum is therefore an attempt to remove the mad from society so that we are not confronted with them. The madman has thus been misunderstood, as well as exposed to unjust and unnecessary discrimination, on the excuse of protecting the public from the 'madmen' and/or the latter from themselves (Foucault, 1961).

Goffman, while keeping his focus on the individual rather than on grand-scale theories about social systems, emphasises how the social structures of mental institutions generate problems of their own. His theories have caused a major debate within psychiatric treatment and institutions (Goffman, 1961; Goffman, 1969; Alaszewski & Manthorpe, 1995). The more moderate reactions to Goffman see psychiatric treatment as an essential part of the problem, claiming that its institutions increases and causes isolation of the patient.

The role of Goffman has been continuously discussed, used, and misused in different settings. Manning emphasises the political use of Goffman and argues that Goffman was seen as an advocate for community health, and as such was a defender of federal policy of deinstitutionalisation. Manning argues that there were groups whose interests were well served by deinstitutionalisation and that for them Goffman became simply ammunition in a battle that had already begun. Manning concludes that much of the singularity and originality of Goffman's ideas have been lost because he has been used in this particular context (Manning, 1999).

Although the discussion of the illness and treatment did have an impact on the deinstitutionalisation movement, it did not gain significant attention until a number of researchers began to look into the condition of patients after they had been discharged from institutions. They found that the patients did well, and that factors in their social network, especially levels of expressed emotions and criticism against the ex-patients, were more significant than other factors (Priebe et al., 2002).

The empirical studies and the coercive control secured by medications, combined with the evaluative and humane considerations, resulted both in the deinstitutionalisation project and in a willingness to try it out. Lamb and Bachrach summarise some of the experiences that have been gained:

> We have observed that community mental heath care is potentially more humane and more therapeutic than hospital care, but that this potential is realized only when certain preconditions have been met (...) With adequate treatment and support, this change greatly improves their lot and leads to a much richer life experience (Lamb & Bachrach, 2001).

Deinstitutionalisation is contingent upon perceiving care as an ongoing social process. Moreover, Lamb and Bachrach argue that much depends on the planning of the service: It must be tailored to individual needs, and hospital care must be available for those who need it. Services must be culturally relevant, and mentally ill persons must be involved in their service planning. Service systems must not be restricted by preconceived ideology. Furthermore, continuity of care must be guaranteed.

Lamb claims that "Deinstitutionalisation is now an accomplished fact" (Lamb, 1998:8). The situation for the majority of patients has been radically changed. Many are able to live in open settings in the community, with family, in their own apartments, in board-and-care homes, and so on. On the other hand, he recognises that there exists a large group of patients, who cannot adapt to the intentions of deinstitutionalisation and are in need of 24-hour care.

> The fact that a significant proportion of this minority are not receiving such care but are instead living in jails, in the streets, and in other unacceptable situations is evidence that adequate community care has not been provided for many of the most severely ill. (Lamb, 1998:8)

Lamb argues that deinstitutionalisation represents a far more humane and therapeutic alternative, as long as it is carried out adequately. The main problem with deinstitutionalisation is to provide enough community resources.

McHugh argues against deinstitutionalisation and says that lack of resources has resulted in a new generation of uninstitutionalised persons who suffer from severe mental illness and are homeless, or have been criminalized. These people present significant challenges to the service system in the USA. McHugh maintains that the ideas of deinstitutionalisation has been abused politically in the sense that it has been used to justify abandoning patients to their fate, which inevitably lead to homelessness and loneliness for many patients (McHugh, 1992).

Lamb counters such criticism by pointing out that this situation is due to *inadequate follow up* and not deinstitutionalisation as such. As regards the problem of crime and public safety, he thinks it is important to find a treatment philosophy that strikes a balance between individual rights and public safety. Since mentally ill offenders are treated in the community, it is essential to have clear treatment goals as well as closer cooperation with, and input from, professionals who know the tenets of both the criminal justice system and mental health treatment. He believes that this type of competence must be consulted "from the beginning" (Lamb, Weinberger, & Gross, 2001).

Lamb points out that outpatient treatment has resulted in the police having become frontline professionals who deal with these persons when they are in crisis. Collaboration is thus necessary, and although the different types of competence should not be confused, it is important that the police "have training in recognizing mental illness and knowing how to access mental health resources" (Lamb, Weinberger, & DeCuir, 2002). This is important not only from the treatment aspect, but also for the police role of protecting the welfare of a community.

Mechanic defends deinstitutionalisation and claims that the challenge is to offer service delivery systems that will preserve the function and limit the disability of patients (Mechanic, 1986). He emphasizes the need to integrate hospitalisation within wider and more balanced treatment services (Mechanic, 1998).

At the rehabilitation unit I visited, it is correct to perceive the home as the goal and wanted outcome of rehabilitation. Perkins and Burns say that most modern-day rehabilitation takes place in the clients' homes and neighbourhoods. They argue that that such decentralisation is a positive strength. They argue further that this is not a problem for the patients because it improves social inclusion, and that personal disability, abilities and strengths are better assessed in relation to an everyday life setting (Perkins & Burns, 2001).

Warner proposes several possible interventions, relevant for operating at a community level that will improve the life quality of patients with schizophrenia. He points to the availability of work, economic disincentives, and stigma (Warner, 1999). He also suggests a number of "speculative" interventions such as: Creating small enterprises that would offer patients the opportunity to work in a mixed workforce, increasing the amount of money they have at their disposal and providing pay above minimal wages; lobbying entertainment media to include positive characters with schizophrenia; and combating stigmatisation and prejudice.

Sue E. Estroff should be seen as part of this discussion, although the way she holds her interest in ideology and empirical evidence together makes her a special case. She seems more radical and explicit with regard to the connection with ideological aspects of the movement. She does not reject the reality of schizophrenia as illness; however, she claims that a significant part of the problems with schizophrenia stems from social structures and the treatment, rather than the illness itself. She claims that, given the right circumstances, schizophrenics can cope fairly well in our society (Estroff, 1981).

Estroff describes how being crazy is part of the self-description as well. She describes how craziness manifests an identity of patients and ex-patients as individuals and a group. 'Being crazy' separates the clients/patients as a group in contrast to 'normal people'. She also indicates that the concept "normal" is used partly as a negative description of 'the others' and 'being crazy' as a positive self-description. She is also interested in understanding 'being crazy' as a way of living. She thus describes the coping strategies in relation to illness, treatment, medications, social security, work, and family. Each aspect offers its specific problems and possibilities.

Estroff maintains that the main problems associated with madness are not just seen in relation to symptoms of the illness, but also related to the social structures the patients were submitted to, the way they were treated, and the unwanted effects of their medications and institutionalisation. She wants to depict how people react to madness and how these reactions contribute to establish the problems that we think of as mental health problems.

Estroff's project is not without problems. Many things have changed since the early deinstitutionalisation movement. It is also common to argue that its main points are now incorporated into modern psychiatry thus making the criticism obsolete. Rothman argues that deinstitutionalisation has now exhausted its role and that the caricatures it created are no longer adequate (Rothman, 1991). McHugh warns that the effects of deinstitutionalisation may hurt those it is supposed to help. He claims that the ideals of deinstitutionalisation have established a potentially dangerous homeless population of schizophrenics in USA (McHugh, 1992).

Estroff recognises that psychiatry has changed as well; moreover, she maintains that the driving power behind this shift must largely be attributed to the contributions made by social science (Estroff, 1981:12). She maintains, nevertheless, that the main problems described by Goffman and Foucault remain the same (Estroff, 2001a). Estroff follows this up by bringing the debate into contemporary psychiatric treatment. Here, the histories of social control are of particular interest.

4.2. The necessity for isolation

Estroff points out how fear of violence legitimates the use of social control. Even her own articles about violence have been used to underline that the mentally ill are dangerous (Estroff, Swanson, Lachicotte, Swartz, & Boldue, 1998; Swanson et al., 1998). She argues, however, against the fear of psychiatric patients as based on myths. Her articles try to undermine these myths by presenting empirical material that shows that the risk of being targeted by violence from a psychotic patient is indeed very small. These claims have been taken as confirmation that there in fact is a risk, and the articles thus confirm that madness represents danger – exactly the position she wanted to refute.

The problem is put to its extreme with the question of whether it is even desirable to demythologise madness. She refers to a conversation in which she was confronted with this:

> If you have to choose between funding the mental health system based on fear of crazy people or not funding it at all, which would you choose? People are not going to fund the system because of altruism – they barely fund education and they actually get something from schools. But fear and need for their own protection – that they'll pay for. (Estroff, 2001a:28)

Estroff admits that maintaining the myths of the dangerous madman will serve the purpose of maintaining budgets for treatment, services, and psychiatric care. It is a paradox that if we were to listen to the 'madman', even the honest intention of rehabilitating and demythologising them could soon bounce back and turn against them.

There is a fundamental problem in maintaining myths despite the pragmatic benefits in upholding them. Estroff argues that the only way to unveil and make the myths superfluous is to approach the subjective experience of schizophrenia. When she quotes what patients actually say, it confirms their sense of exclusion. She refers to stories, testimonies and poems that include descriptions of being living dead, as well as experiences of degradation, humiliation, and outrage, all of which stand in connection to being held back against one's own will. Patients speak of having important and personal experiences reduced to 'not-real', or just fantasies, or side effects of medications, and the effect of hospitalisation.

Estroff emphasises ethical values as the primary driving force behind the deinstitutionalisation movement. She also contributes to the empirical data. Efficiency is advantageous, but human rights and freedom are essential. She thus represents a more radical position within the debate and with the intention to emphasise the ethical and human aspects of treatment. The intention of her research is to secure help (effect) as well as ensure that the help provided is humane.

4.3. Ideas behind the rehabilitation unit

The rehabilitation unit was a relatively young institution. Many of the staff members had previously been engaged in gaining acceptance for the rehabilitation idea for treatment locally. It was described as both a political and professional struggle. The staff had experienced themselves as being in conflict with the prevailing view of psychiatric treatment, and they wished to offer an alternative form of treatment.

A rehabilitation program had been set up as a pilot project in order to establish the unit. It included a limited number of patients (16) over a five-year period. The experiences from this project were summarized in a report, in which they argued that rehabilitation is a good and adequate treatment in the sense that it has realistic goals and contributes to increase the quality of life of former patients (Viken, Eckhoff, & Liland, 1997). It also has the intention to train clients to carry out everyday tasks, which they reckon will reduce the risk for rehospitalisation.

The current rehabilitation unit included ex-patients who had had extraordinary problems after hospitalisation. The service is primarily seen as the extension of the treatment, but it was initiated only after hospitalisation had ended. The rehabilitation was successful with regard to rehospitalisation, meaning that patients who had not been successfully rehabilitated previously are now able to live more independently from the institutions. Then there is the human aspect: The patients expressed a great deal of satisfaction with both life and the service offered by the rehabilitation project.

> Almost all of the patients are satisfied with the recent development in their life; moreover, all are more satisfied with life than before. This is the case despite the fact that they still have their sufferings, which give troublesome symptoms and reduced functioning: If you have reduced expectations to life, then the joy will be all the better when you experienced bettered conditions of life. (Viken et al., 1997:129)

The rehabilitation unit cannot be seen as ”anti-psychiatric” or in direct opposition to the use of drug therapy or institutions in treatment of schizophrenia. It is more relevant to see their work in relation to the suggestion made by Mechanic and Lamb, who ask for flexibility and complementarity between medical treatment and the social and health services. Informants among the staff frequently expressed an underlying idea that “this is how psychiatric treatment should be done”, because it works and it takes care of the integrity of the people involved. By integrity, they meant both patients *and* staff. They did not reject the legitimacy of the institutions; however, they suggested an alternative use of the resources. The treatment should follow the patient as long as necessary. Among other things, it would mean a transition period between hospital and home. *Continuity* was important in order to secure stability so that the patients could establish confidence in individual staff members over time. *Flexibility* and meeting *individual requirements* were accentuated because the patients had very different needs. *Availability* and a high degree of *care* were seen as essential.

One patient expressed the need for available help, saying that knowing he could reach a staff member if necessary was reassuring. He argued that having the help available often meant that no help was needed. The need thus becomes visible only when a service is discontinued.

Participation by the inhabitants, on both an individual and a social level, was seen as essential. It meant consciousness of, and responsibility for, one’s own situation. Participation was seen as a good way of activating and engaging patients so that they could develop their personal qualities and interests. In addition, rehospitalisation was used when necessary. The head psychiatrist spoke of rehospitalisation as going "back and get some rest". Rehabilitation can be a demanding and exhausting process. Rehospitalisation may therefore be seen as part of the process, and not a failure. The goals of rehabilitation could lie "years into the future". Relapse was, after all, a matter of the "here and now".

Despite this flexible view of hospitalisation and everyday life, there was a conflict with established, traditional psychiatry, mainly because this flexibility and patient oriented model were problematic. For instance, several patients indicated that they experienced the diagnostic language as degrading. In dialogues with personnel, they therefore developed alternative descriptions based on everyday language. This could include rather trivial matters like referring to hypomania as 'active periods' or 'unrest'. One nurse said about a dialogue with a contact person at the hospital concerning a rehospitalisation:

> He did not like the descriptions like hypomania or manic, he preferred the phrase active and hectic. We came to terms with that, however, when I spoke to the hospital and said: "He is now in an hectic period." They replied: "I reckon you mean that he is hippomaniac?"

She could understand the hospital personnel since a clearly defined diagnosis is required for hospitalisation. The problem was that it was experienced as a step backwards from everyday descriptions that in many cases were seen as more than adequate and suitable to deal with these kinds of situations in everyday life by the person it concerned.

The conflicts made it necessary to clarify the notion of normality and illness. Both staff and patients were initially faced with a rather peculiar dilemma: If the person had recovered, there would be no legal requirement for municipal service efforts. On the other hand, if the patient was still ill, why should they be discharged from hospital? Informants among the staff saw this as a dilemma, which was a result of conservative views, and as a lack of flexibility in the perception of illness. The controversy concerned whether rehabilitation was a correct response to chronic schizophrenia, rather than the idea of rehabilitation per se. In practice, it also meant a difference as to which instance that had to 'pay the bill'. If patients were discharged, they became the responsibility of the township. If they belonged to the hospital, the state was responsible for treatment. Because of the finance system and shortage of founds, patients were passed on from one institution to the next, a form of rejection that was experienced as both degrading and exhausting. The patients' resources and qualities were overlooked or unappreciated; besides, the conflict made impossible the security about the future that patients as well as staff needed in order to keep up their faith in the goals of rehabilitation. They, therefore, had to find a practical solution to this situation.

Discharge from hospital implied that the hospital had completed its treatment service; that is, the hospital could not offer treatment that would further improve the life situation of the patient. It did not necessarily mean that the patient had fully recovered. Furthermore, discharge without a transition period had previously resulted in relapse and rehospitalisation for some patients. The institution was the only place the patients mastered and a certain changeover period was necessary to free them from the habits of the institution and prepare them for life outside.

Staff did legitimate rehabilitation by ethical arguments, too. One staff member said, "Rehabilitation to me is to restore lost honour and dignity". He saw honour and dignity as something patients had lost, or been deprived of, due to their illness. The rehabilitation process was supposed to re-establish dignity, something every human being should expect for himself or herself. Some staff regarded rehabilitation as something society owed these patients.

Part of the resistance to the hospital was therefore based on *ethical evaluations*, often in the form of accusations that the treatment model did not see the patients as human beings with the same rights as others. It was, therefore, a natural consequence that patients could experience treatment as degrading and feel that it made them even worse. Two of the staff members also said that participating in the treatment made them feel bad about themselves for taking part in such a system.

The criticism of the hospital incorporated some of the ideas of deinstitutionalisation, however, I see this more as an expressed wish to reform, rather than to replace or to dispose of existing institutions. The criticism takes the individual patient's point of view and bases its claims on essential ethical values and principles within our society. The critics did not reject the diagnosis or the clear concepts of illness and disease connected to the suffering of the patients.

It was also recognised that the political fight had a positive effect in that it increased the staff's motivation and made it necessary to clarify their intentions. The struggle united staff and inhabitants in a common battle for defined goals. On the other hand, it put a significant personal strain on the individuals involved without any certainty of long-term effects. The main struggle happened during the trial project that lasted five years. When the unit was established, it was seen as an indication that they had established local understanding of the advantage and necessity of offering an extended rehabilitation period to certain groups of former patients.

4.4. First-hand experiences and the professional helper

In what way may the discussion of first-hand experience assist us in approaching the problems of relating to patients with schizophrenia? Strauss and Laing differ in many respects and emphasise different approaches to the subjective experiences of the patient. There are, in fact, no obvious parallels between Laing and Strauss, so it is necessary to see them as two separate inquiries into first hand experience. Still, they both emphasise 'subjective experience', which is a rather peculiar concept. They think it represents an aspect that is already present in clinical practise. The question is whether their focus on subjectivity is a fruitful approach to the narratives of patients and staff.

R.D. Laing is for various reasons associated with the anti-psychiatric movement (Crossley, 1998). Clarke argues this it is only due to a (false) allegation made by Cooper (1968) that Laing had said that schizophrenia did not exist, and that if it did, schizophrenics operated on a higher spiritual plane (Clarke, 1999:313). Anyway, Laing directs his interest towards the potential for understanding, a potential that he thinks is already at hand. It could justify seeing this as an *internal* discussion of psychiatry, although a main concern of Laing is whether psychiatry really seizes its possibility, or whether it overrules and rejects it due to a false perception of its scientific and clinical basis. This is especially evident in his discussion of subjective experience.

Schizophrenia is a central theme to Laing, even though he maintains that psychiatry has misunderstood both the nature (Laing, 1969:53-62) and the possibilities of schizophrenia (Laing, 1982:63-81). He tries, as an alternative, to see schizophrenia as a cultural problem rather than a psychiatric one. The notion of experience plays an essential part in his view of psychosis (Laing, 1969) and in his view of the philosophy of science and psychiatry (Laing, 1982). He also uses case histories in a manner that finds their legitimacy in the evaluation of subjective experience (Laing & Esterson, 1970).

Laing argues that scientific assertions must have an empirical basis. "The experience of an objective fact or abstract idea is not the impression or idea" (Laing, 1982:9). He says that all experiences must be regarded as *instances* of experience. The *objective* view is useful for certain purposes, although, he says, "nothing is more subjective than objectivity that is blind to its subjectivity" (Laing, 1982:17). Both subjective and objective presentations have their advantages and limitations. An *objective* description, in contrast to a subjective one, will utilize a language that is not dependent on time and place.

Laing distinguishes between *depiction* and *description* in order to account for differences in presentation. Depiction is showing or demonstrating something, while description means using neutral language to describe it. In the case of music, for example, we can use pitch, duration, and the succession of tones to describe what we hear. This would describe what was heard in an objective language, according to Laing, and would be a description that might be agreed to as true or false. However, the *subjective experience of listening* to music and its *objective description* are clearly different. Laing suggests depiction to deal with the subjective experience of listening: I could show you what I meant by playing the piece of music. Subjective and objective experience represents different ways of describing something, and they fulfil different purposes.

The main problem with objectivity, according to Laing, is not a methodical or theoretical concern, but an ethical one. It is constituted by the distance objectivity establishes between the scientist and the 'object'. There is nothing *scientifically* wrong in this distance; on the contrary, distance will sometimes be a necessity in order to conduct experiments. Laing uses the example of a dissection that first seems macabre. It therefore comes as a relief when he says that it was a dissection of a salamander and not a human being that was described, although he does think that there is nothing scientifically wrong in describing and conducting the same experiments on humans. The reason is that our reactions are not based on science, but on ethics. Ethics then comes close to being scientifically *irrelevant* or, instead, representing something that is added and will only restrain the scientist.

Laing then turns his attention towards technical and diagnostic language, which he sees in close connection to the concept of 'objective' experience. This kind of language inevitably keeps the patient at a safe distance, instead of accentuating the subjective experience that is unfolding before the therapist's eyes. This is, however, a distance that soon becomes problematic in everyday practice because ...

> … It is difficult to keep a safe distance from a psychotic if one is 'seeing' him day in and day out in analysis. They try to worm their way under one's skin. They try to occupy one, to preoccupy one. They baffle and bewilder (Laing, 1982:50).

Closeness is, however, only a problem for the idea of objectivity. Loss of distance means loss of objectivity and, for that reason, it is also seen as a loss of professionalism. Instead of letting loss of distance be a problem, Laing suggests that it is the idea of objectivity that is the problem. He emphasizes how subjectivity may turn out to be to the therapist's advantage. He also claims that this perspective has been present in psychiatry all the time. Psychiatry cannot be an objective science, and this, according to Laing, is its greatest advantage.

Laing also mentions another type of subjectivism hidden within objective language. Persons become biased not only by clinical encounters and subjective experiences; the theoretical aspects also represent a bias, although this is less conspicuous. Objective knowledge offers a kind of subjectivity that not only abstracts itself from the individuals, but also hampers the understanding of what patients actually say about their own experience. The emphasis on subjective experience therefore aims at rehabilitating the clinical foundation that marks psychiatry as a profession. The problem of objectivity as requirement for professionalism is that it undermines the subjective aspects of the clinical encounter and turns it into a potential problem.

In Strauss, on the other hand, there is no comprehensive theoretical discussion about experience. However, he does accentuate subjective experience as an essential part of psychiatric competence and practice (cf, Strauss, 1996; Strauss, 1994; Strauss, 1989). According to Strauss, health professions have a tendency to ignore or avoid many aspects of what the patients say about their own experience of schizophrenia or other sufferings. Instead, Strauss recommends a closer look at the experience of the patient. He argues that subjective experience is a key to understanding the interaction between illness and person, and that subjectivity contributes positively to the treatment.

'Psychotic' actions, for instance, will often appear bizarre and unmotivated, but that does not necessarily imply that such actions are unintelligible or unmotivated. All we can say is that we do not see any coherence, which does not necessarily imply that the person himself sees his actions in this way. Strauss' suggestion to investigate the subjective experiences and intentions will fill in those pieces that are necessary to understand any human conduct. He admits, however, that relating to the subjective experience of schizophrenia stands out as both difficult and controversial to conventional psychiatry.

Strauss therefore claims that closer attention to the subjective experience of schizophrenia reveals the interaction between the person and the disorder. Discovering the person as a "goal-directed being" is important for progress (Strauss, 1996). Both Strauss (1989) and Estroff (1989a; 1989b) criticize psychiatry for ruling out subjective experience as irrelevant to the understanding of mental illness. Disregarding the subjective perspective of the patient also implies that one stops thinking of the patient as a person, although a one-sided focus on subjective experience does not solve the issue as a health problem.

The actual and specific experience of the patient is a key phenomenon in understanding the interaction between the illness and the person. Strauss argues, referring to empirical studies as well as to common sense, that a focus on subjective experience will have a positive effort on the treatment. Strauss criticizes the idea of objectivity usually inherent in pathological and scientific language because of the tendency to disregard the individual aspects of treatment.

According to Wifstad, diagnostic language is mainly based on a reflection on universality inherited from positivism. A focus on individuality will consequently be criticized as unscientific and not epistemologically founded (cf, Wifstad, 1997). There is consequently a contrast between the scientific and the clinical foundation of psychiatry as a profession.

First-hand experience is subjective. Each individual is considered unique and thus possess a unique perspective. Strauss still claims that experience is a source of knowledge, which transcends the subjective individual and has universal character. Hence, 'Subjectivity', as such, is beside his point and becomes a redundant and empty concept. Strauss wants to bring the *experiences* of patients, relatives, and staff into focus and look at them as an essential resource. In order to maintain the focus on the individual, it is necessary to examine the philosophy of science that hinders this aspect.

What consequences does the criticism mentioned above have for psychiatry? The criticism is not so much a dismissal of psychiatry as a way of *dealing* with mental illness, but the critical view emphasises an aspect that is already present within psychiatry due to its clinical nature. Clinical practice reveals an already present and natural basis for psychiatry that is seen independently from the official scientific and pathological foundations. This comes to concrete expression when you ask clinically trained personnel about mental illness. They often recapitulate textbook definitions or articles. However, if you ask them what they mean, or ask for elaboration, they usually tell stories that explain or exemplify what they mean.

Psychiatry concerns itself with individuals who tell unique stories. The individual perspective will always be subjective experiences and expressions. It is possible to combine the perspective of the patient with a concept of knowledge already present in psychiatry. Psychiatry can hardly be imagined apart from narratives. The narrative aspect is already present in psychiatry due to its close relation to clinical practice.

The use of the terms 'subjective' and 'objective' represents a problem to both Strauss and Laing. Even if their intention is to avoid the threat that objectiveness and abstraction take them away from the individual perspective, by making use of the same terminology as their opponents, it is unavoidable that they are made captive of their opponents' manner of speaking and thus of their manner of thinking. Alternatively, it would have been possible to avoid the subject-object dichotomy. It is not the subjectivity in itself that is important, but rather the actual experiences of patients and staff. The notion 'subjective' is actually superfluous in this context. When Strauss calls experiences subjective, he means that they are individual, existential, and sometimes even unique. Laing emphasizes that 'objective' experience also has inevitably 'subjective' aspects in addition to the limitation of the focus that objectivity may imply. Despite this, Strauss' interest in experience comes from the fact that he sees it as a source of knowledge that has *general validity* or at least validity *beyond the private* sphere. 'Subjectivity' transcends itself. One might therefore ask whether the effort actually is to establish a concept of subjectivity *despite* subjectivity. Is the intention to stress 'subjectivity' rather to be perceived as another form of universality and not as subjectivity per se? The expression 'first-hand experience' suits the intention better, even though 'first hand' does not say how we are meant to deal with the subjectivity that will be part of that experience.

Science must not generalise to the degree that it loses contact with the underlying experience. The focus on "narrative language" already present in psychiatry as clinical practise, could offer an opportunity to approach the 'universal' through particular instances. Psychiatry has to deal with individuals mainly through their stories. The narratives we have in mind when talking about schizophrenia, are often presented in an extraordinary setting and with extraordinary content. When we quote, we refer mostly to fragments, anecdotes, and expressions of how things are going; still these quotations are presented in an overall picture and idea of the underlying phenomenon. This constitutes a basis for psychiatry as a hermeneutic science, which means that the discussion of subjectivity may fall into place as a resource and as a part of the way human beings relate to and understand each other and the world.

5. EXPERIENCES WITH MEDICATIONS

The introduction of drug treatment has considerably altered the situation of psychiatric patients. The question then is how to evaluate changes caused by drugs. The factors involved in the change overlap and interact with each other and are therefore difficult to interpret. The inquiry depends upon other concerns including not only the concepts of illness, but also what it means to 'recover' or 'improve' from schizophrenia, as well as how the treatment itself influences the person involved.

In what manner do staff and patients find drugs to be helpful? How do different views on what it means to improve affect their evaluation of drugs? Non-compliance and patient autonomy are crucial topics. Some patients, who experienced drugs as helpful, still resisted taking them. Expressions of protest did not necessarily imply that patients find the positive effect as marginal or absent. Non-compliance may thus seem *contradictory*: If you actually feel helped, why resist effective treatment? On the other hand, non-compliance opened a discussion about *how* medications helped and what help patients actually wanted. That is, how did the improvement help or hinder the patients achieve their vital goals?

5.1. The problem of non-compliance

There is a consensus in articles on neuroleptika that anti-psychotic drugs improve the situation for patients suffering from schizophrenia. Improvement is estimated with regard to presence of symptoms, rehospitalisation, and quality of life. The studies are designed to look at improvement with regard to rehospitalisation, quality of life, and symptoms (Bhana, Foster, Olney, & Plosker, 2001; Revicki, 1999; Bilder et al., 2002; Breier et al., 2002; Briken, Nika, Krausz, & Naber, 2002; Chouinard, Annable, & Campbell, 1989; Davis & Chen, 2001; Dursun

& Deakin, 2001; Heresco-Levy et al., 2002; Kane et al., 2002; Levinson, 1991; Umbricht et al., 2002; Van Putten & Marder, 1986; Volavka et al., 2002).[3]

On the other hand, a number of studies describe a large extent of non-compliance with regard to the same types of medication. Depending on the criteria applied, studies indicate a non-compliance rate of 19 to 63 per cent among this group (Olfson et al., 2000; Young, Zonana, & Shepler, 1986; Estroff, 1981). Furthermore, non-compliance is shown to be the most frequent cause for rehospitalisation (Marder, 1998).

The disparity between the documented effects and compliance could be explained as a lack of insight. On the other hand, due to the particular character of neuroleptika, it is necessary to ask what neuroleptika has an effect on. How does it help?

There is no doubt that medication changes the life of a patient drastically with regard to the effects of the illness. The question is how this "new" life on medication compares to a (assumed) life without medication. It is not necessary to challenge these results; on the contrary, the following paragraphs presuppose that the epidemiological data constitute a valid map of the area. What does the research actually tell us?

- Weaker symptoms of disease
- Presence of troublesome side effects
- Fewer days in hospital
- Higher score on quality of life
- A large percentage of the patients refuse to be treated with drugs

Why do patients refuse to receive treatment that is documented as effective? The greatest problem with this question is that it is never asked explicitly to patients; at least, it is impossible to come up with studies in which patients have been asked why they refuse treatment. It is thus necessary to deal with the expressions of protest in a manner that does not disqualify them. Instead, the complaints of schizophrenic patients are often understood as confirmatory of

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[3] Documentation of the effect of antipsychotic medications is extensive. I have limited my search to Clozapine and Haloperidol. I have also limited the number of references to a representative selection because methods are more or less the same, and results are mainly reproduced.

symptoms of the illness. Alternatively, the reported problems are seen as unavoidable side effects, or as a calculated risk of the treatment that after all does benefit the patient.

Medication was a frequent subject of discussion among patients and staff. Questions related to drugs were often subject to lasting conflicts between patients and staff. Drugs had a vital impact on the life of the patients. Opinions and attitudes concerning this aspect of the treatment were, therefore, strong. The experience with drugs could however be both positive and negative.

All anti-psychotic drugs have various disagreeable and unpleasant side effects. The use of drugs will always be a trade-off between problems and benefits of the treatment. The presence of both weakening of symptoms (improvement) and side effects (deterioration) has informative value with regard to non-compliance. Positive and negative effects measured in terms of the presence of symptoms and side effects do not cancel each other out; the person is instead subjected to the full weight of the unwanted effects of both treatment and illness. This, rather than lack of insight, is a crucial fact to understand when patients feel they are not being helped by medication, especially when the drug therapy results in improvement.

Weiden et al argues that a significant proportion of patients with schizophrenia will, for this reason, always need depot therapy because improvement makes patients become more in touch with their "losses and painful inner feelings" (Weiden, Aquila, & Standard, 1996). This is especially marked when the main effect of the treatment is to weaken the symptoms of illness. Then the symptoms of treatment will become dominant in the patient's own experience and consequently define their main problem at that time.

The alternative approach could be to ask how medication affects the important individual goals and thus orient the effects based on patient goals and intentions. Will it become easier to make friends, achieve personal goals, function in a job, or maintain a household when treated with neuroleptika? If withdrawal and exclusion is the problem, then the way known side effects influence social skills becomes essential. The empirical aspects of the extent of the problem are of interest, but there are also logical (necessary) connections between known phenomena such as lack of concentration, restlessness, and isolation (Estroff, 1981:111-117).

First, the problem primarily indicates a tension between wanted and unwanted effects of drug treatment. In other words, refusal is not necessarily based on an assumption that drugs *do not work*. Second, it is essential to study the manner in which drug treatment affects the possibility to live out one's potential as a person. Accepting that drugs do in fact help raises the question as to *how they are helpful*. Are they an extension of the patient's ambitions and intentions, or alternatively, do they fulfil the ambitions and intentions of family and/or staff? These two elements are important in order to understand the phenomenon of non-compliance or, at least to comprehend why it is easy for patients to find faults with the drugs and refuse treatment.

5.2. Drug treatment and rehabilitation

Drug therapy was seen as an inextricable part of the treatment of schizophrenia. In addition to the direct influence drugs had on the individuals, it also had an indirect effect on the context. Despite problems, staff members justified drug use as essential if patients were to function in everyday life.

Mechanic argues that the need for institutions has changed due to medications. He points to a possible connection between the introduction of drug treatment and the deinstitutionalisation process.

> One might believe that the demise of the public mental hospital was solely due to the introduction of neuroleptic drugs in the early 1950s. The development of new psychiatric drugs in recent years is a significant advance and contributes a great deal to successful treatment. But today, even more than in the past, there is overzealous promotion of these drugs and a misconception that little more than better drugs are required to deal successfully with psychiatric morbidity. (Mechanic, 2001:468)

Mechanic identifies both positive and negative consequences for the patients of the introduction of drug treatment. He acknowledges three ways in which medication has been significantly helpful for patients: first, it became less difficult to manage many patients; second, it gave hospitals and families confidence that they could reduce coercive control; third, it increased public confidence in relocating patients as a viable option. In other words, the positive aspects are associated with the *indirect influence* drugs have on the *social context* of the patient. Mechanic thus sees the indirect effects as more important than the direct effects medications have on patients. Furthermore, Mechanic maintains that there is *overconfidence* in drugs and that research and usage is based on *oversimplification* of their effects.

The attitudes among patients towards drugs are problematic. Mechanic argues that the problem arises because the framework and context in which complaints of the schizophrenic patients take place are different from that of other groups of chronically ill patients who also complain about their treatment. It is thus of secondary importance whether schizophrenic patients complain more or less than others about their treatment, the main question is how we can deal with the narratives of protest. Mechanic deals with these narratives by raising the question regarding the adequacy of the basic concepts in which the *effects* are measured.

The discussion of drug treatment highlights the need for seeing several aspects as a whole. Sue E Estroff argues that it is also necessary to maintain a complete picture of the experience of the illness. The experience of schizophrenia is made up of several aspects that may have different causes. Instead of separating the different aspects of treatment and illness, she argues that we must describe the totality of *the experience of being treated.* If we are to speak of improvement or deterioration, we must evaluate all aspects of the life of the patient and not just some aspects of it.

The first step is to decide how to describe the problem. Estroff emphasises isolation and passivity. In that case, several aspects will affect the situation simultaneously. She maintains on the one hand, that it is possible to separate illness, hospitalisation, stigmatisation, medication, and side effects; on the other hand, Estroff rejects this as a workable approach because it overlooks the complex nature of the illness and how symptoms of illness and treatment are interwoven. She suggests instead the use of *'symptoms of treatment'* to denote the experience of the situation of undergoing treatment as a whole.

> Symptoms of treatment is a term we use to include medication side effects, experiences in inpatient and outpatient treatment settings, and the sensate and emotional responses of [Patients] to mental health professionals, fellow patients, and family members. (Estroff, 2001a:6)

This concept is directed towards the experience of being treated as an immediate and overall impression. It is especially relevant with respect to questions regarding drugs because the 'symptoms of treatment' and the symptoms of illness constitute a joint, overall experience of the situation for people with schizophrenia.

There is an interest in iatrogenic symptoms or illness the last couple of years within general practice of medicine. Iatrogenic illness is established as a term that articulates problems caused by the doctor (Sharpe & Faden, 2000). It is an effort to articulate that a medical consultation isn't a 'neutral' act. Examples of this may include, for instance, the problems that occur because the health of assumed healthy people is 'questioned' in order to rule out illness, or the problem of being a 'false positive' during a screening programme, or again ending in a high risk group and treatment in prevention of illness. Furthermore, concepts like iatrogenic illness may help to articulate the role of the doctor and the problems concerning patient empowerment.

The concept 'symptoms of treatment' is unique for Estroff and goes further than the sole focus on the doctor. Her intention is to hold together all the different aspects of treatment, not only side effects and 'intuitional syndrome', but also stigmatisation, exclusion, discrimination, and so on. The focus is thus not only on the specific *psychiatric* treatment, but also on *psychiatry* as an important part of the way our *society* treats people with severe mental illness. It is an effort to sum up the *unwanted* effects of treatment.

Patient complaint and experience could often incorrectly be attributed to lack of insight or awareness of one's own situation; that is, failure to separate the effects of the drugs from the disease and failure to see the *positive effects* of the drugs. On the other hand, we must not forget that symptoms of schizophrenia and known side effects of neuroleptika resemble each other – not only from the first-hand perspective, but also from the second-hand perspective of the experienced clinician. Kringlen (1982)[4] admits that it is difficult to present a clear picture of what the illness might look like in itself. The illness may have a gradual development, and its symptoms may become blurred with results from long-term treatment that will involve both hospitalisation and medication. For instance, symptoms affecting the will, especially lack of interest and resignation, are often associated with the effect of institutionalisation, as well as of the illness itself. In any given situation, all types of symptoms will be present.

Estroff argues that the domains 'illness' and 'treatment' cannot be separated without failing to see their essential entanglement. The separation will contribute to an enduring disagreement about both subject and subjectivity because scientific assertions on schizophrenia do not account for, or even exclude, the experience of illness in those affected.

The availability of anti-psychotic medications has lead to a change in the experience of chronic schizophrenia; rather than having to live with the symptoms of the illness, patients now have to live with the symptoms of treatment. Treatment must then be seen in a wide sense. These examples present aspects of treatment that affect a person in ways that can be seen as different from the illness.

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[4] Kringlen is a well-known Norwegian psychiatrist and author of one of the most widely read textbooks of psychiatry in Norway.

5.3. Normality and the problem of status quo

The person who describes the change and/or effect is always significant. First and second-hand experience with medications often differed considerably. Instances that were seen as improvements from a second-hand perspective could be experienced quite differently from the patient's point of view.

Patients did not use the medical meta-language to articulate their experiences. Their statements of protest and approval were expressed in everyday language and their examples were more concrete. Overall, staff and patients seemed to agree in their perception of the *effect and side effects of the drugs*. Where they disagreed was in their views of what it means to *recover or improve*.

Staff described *stability* as a positive feature because it offered a possibility for training the patient for an *independent life*. The precise qualities this life should include were agreed upon in collaboration with the patient, which meant that they were generally open to individual variation concerning which qualities were essential. Patients were concerned about self-control and autonomy, as wells as their general situation. They often expressed a wish for a 'normal' life, which meant ordinary achievements and goals such as education, a job, a family, and children. Their ambitions were often modest.

The unit staff expressed a balanced view on drugs. They were well aware of the problems of side effects. The potential for cooperation about treatment should therefore be present. On the other hand, staff justified drug treatment as not only necessary but, also as the best option for the patients. When asked whether drugs were *more* important than the other factors for rehabilitation, staff said no. Drug treatment was seen as a necessary condition that could make rehabilitation possible. It was not seen as a guarantee in individual cases, but as an aspect that benefited the process of rehabilitation. When asked what they thought would happen if patients stopped drug treatment, the opinion was that this would not go well.

Even though medication may help *stabilise* their situation, drugs are not necessarily experienced as a *positive* factor by the patients, even if their quality of life improved. Stability could also mean that it is impossible to get on with life, or that one would never improve beyond the present situation. One patient described sorrow for the life he never had and never will have. Stability is a major problem. He said that all his friends and relatives had families and jobs while he was stuck. He lived at different institutions while they moved on. He thought that his life was wasted because of his mental problems. He said that he did not ask for much; only a girlfriend and a place to live, but he did not think he would ever experience this.

Another type of concern was the fear of medications itself and especially the fear of being addicted. Patients were well aware that people do not normally need medication in order to deal with life; it was therefore a problem that they themselves did, because it meant that they would never 'get well'. The staff were attentive to this concern, and had a great deal of sympathy for the inherit conflict. The head psychiatrist confirmed view this and continued:

> It is the same as never getting well; but then I usually tell them that this is also true for most other major groups of diseases. It is true for all the chronic diseases where you need drugs to continue life, or going on without pain. Rheumatism, insulin-dependent diabetes, (…) different forms of cancer where one is dependent on treatment as long as one has the cancer to stay alive. These are diseases that one doesn't get well from and where one has to use drugs all the time.

However, he understood the objection that the comparisons with most other diseases lack the kind of stigmatisation that is connected with schizophrenia. The analogies to other illnesses that were made to claim that life-long treatment was normal were thus rejected by patients. There is a significant difference in people's attitudes to a schizophrenic and a diabetic. There is therefore also a significant difference in accepting that one will never recover.

5.4. Importance of first-hand experiences of improvement and deterioration

Patients discussed drugs among themselves. They could encourage or dissuade each other, and sometimes they had specific discussions on different brands of antipsychotic drugs, which centred on the patients' own experiences with taking them. Their reluctance was difficult to connect to lack of insight or knowledge. The knowledge they had also concurred with other sources of information. However, the focus was on the aspects of treatment that were seen as a hindrance or a help to achieving personal goals. This does not imply that the physical side effects were unimportant. For instance, akinesia is small muscle contractions and feels like tickling. According to an informant among staff, this problem can be so annoying that it can drive people crazy or make them commit suicide. It is obvious that this represents phenomena that not only interferes with the ability and capability to act, but is a situation that is unbearable in itself.

The patients did show a broad spectrum of attitudes toward drugs. Attitudes would also change over time. Some of the strongest opinions, positive as well as negative, might be suspected to stem from a lack of insight/knowledge; however, most of the time the patients' opinions were reasonable and relevant. Moreover, they concurred with scientifically proven side effects. The difference was how the side effects were evaluated.

Resistance against coercive control was central. The patients had years of institutional experience behind them, and they strove to maintain a personal space that was perceived as private. Some managed to define their rooms and belongings as their own turf. These arenas could then be defended accordingly. Personal space could be marked by decorating, but also by controlling who had access to their rooms. Intrusion into or regulation of the private area was often fiercely resisted. However, in any institution even private rooms are subjected to cleaning and inspection. The staff tried to dampen this by trying to gain invitations or establish appointments; however, the purpose of these visits would still be obvious for both parties. Moreover, the unit was small, so it was difficult to hide or avoid the glance of the others.

Most patients were thus left with little space of their own. Their body was the last and most important line of defence, the last thing they could keep control over. Denying treatment was then an important expression of autonomy, and it did not necessarily imply that they did not feel the medication helped.

Some patients accused the staff of using drugs to keep control over them. Staff indirectly confirmed this in stories about occasions when they lost control over patients because they had stopped taking drugs. Drugs were also described as a better option than the use of force, in the form of, for instance, straps or isolation, when it became necessary to protect patients from themselves or others. Although the argument is based on what is seen as being in the best interest of the patient, it also illustrate that control is seen as part of drug treatment.[5]

Patients spoke of being helped by medications. Patients might feel that drugs helped, despite the problems they experienced when using them. One patient described his suffering and difficult experiences at the time of hospitalisation. These problems stood in contrast to his present situation. He attributed much of the change to drugs. The change was based on the

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[5] Usage of Pharmacological means was reviewed with regard to Law of Psychiatric Treatment and regulations regarding compulsory treatment by a Norwegian official committee. Pharmacological means could be considered as measurement of compulsion in legal terms when it is used to control behaviour against the will or knowledge of a person (Norges Offentlige utredninger, 1991)

experience of improvement in his current life situation and was related to Leponex (Clozapine). He nevertheless remained ambivalent towards the drugs: A 'higher dosage' was regarded as being on the safe side. On the other hand, he was eager not to receive too much because that was unpleasant. He especially complained when he felt that staff did not take his complaints seriously. Still, this patient was afraid of becoming ill again in the same way he had experienced before, so the medications were chosen despite their side effects in order to avoid the possibility of having to go through another 'psychotic crisis' (patients' own expression).

This does not mean that the informant did not experience the side effects as annoying and troublesome. "I'm always tired and cannot concentrate." "The medications make me forget." "My thoughts move slower." These are all known side effects of these kinds of medications; it is, however, important to notice the context in which they appear. These complaints occurred usually in relation to things the patient would have liked to do, but did not feel capable of doing due to tiredness or lack of concentration. What he would have like to do was to get an education, start a family, keep up contact with friends, and in general get on with his life. Another patient described how difficult it was for her to read a book.

Knowledge about medications, treatment, and illness. The patients were interested in drug treatment and demonstrated good knowledge of their own, as well as alternative medications. The knowledge implied first hand experience and entailed detailed statements about specific problems that appeared with different doses (often stated in mgs), but also of the problems that would disappear. Relevant issues were less trouble with side effects, that they felt better, and that one avoided injections.

Choosing the illness. Some patient statements indicated that they preferred the illness to the drugs and that the medications deprived them of important personal goals or prevented them from doing things they wanted to do. Loss of virility and problems of overweight were particularly pronounced, as were difficulties concerning a "flattening" of the emotional life or lack of concentration.

A psychiatrist described the effects in the following way:

> ...The emotional life is dampened. One does not feel so strongly. If you get angry, it becomes less, if you are very afraid, it becomes less frightening.

However, drugs also dampen positive and desired emotions. Another staff member articulated another problem:

> He makes complaints that we try to kill him with the medications. In a way, he is right because the medications take away his emotions, emotions that define him as a person.

If we look at the pro et contra of the argumentation, positive expressions about drugs from patients were rooted in *personal experience of improvement and worsening*. Problems that disappeared or arose were part of these experiences. If a person felt strongly troubled by side effects, the *personal experiences of worsening* when dropping medications were an important argument in favour of drugs. The severity of side effects the individual patient accepted stood in relation to how *troublesome* the person experienced the illness. Problems arose when a patient did not see the illness as the problem, but others in the environment did.

5.5. Possibility of concordance

In recent years, the concept non-compliance has been criticised for evaluating treatment in terms of patient's adherence to the doctor's prescription. In some cases, it makes sense that a cure should be continued also after the patient feels healthy. In other cases, we could talk about an intelligent non-compliance when, for instance, a patient stops or changes doses of medications against the prescription because of experience of worsening, side effects, or lack of effect. Concordance is suggested as a concept that sees treatment as a joint consultation and agreement with regard to treatment (cf, Vermeire, Hearnshaw, VanRoyen, & Denekens, 2001).

Concordance presupposes not only that patients are given insight into and knowledge of medications, treatment options, and their illness, but also an empowerment which means patient autonomy and the possibility to act. Hvas & These describe empowerment both as mobilisation of the patient's own power and as opposition to oppressive forces. For the most disempowered patients, the aim of empowerment is to achieve fundamental changes in control and influence (Hvas & These, 2002).

Although staff and patients may have different goals with the treatment, an agreement with regard to the effects and side effects of drugs could be sufficient for cooperation. This may imply that a patient is allowed to reduce doses against medical advice. This creates the possibility of gaining first-hand experience with improvement and worsening, which is not just necessary for patient motivation, but also in order to 'test' the treatment, find a balance, and remain in positive control of a treatment that for many will be life-long. Many staff members were well aware that there was a conflict between the patient's view and their own duties at the institution. When confronted with the effects of medications, staff members argued that despite the side effects there were no other options.

> It is true that many of the patients have negative experiences with the medications, but the alternative would be to use measures of restraint and isolation. They would be more afraid, and isolate themselves.

In other words, staff did not disregard problems concerning medications; however, they regarded these problems as less important compared to what the situation would have been without drugs.

On the other hand, the inhabitants regularly expressed a desire to stop using the drugs. The psychiatrist complied to some degree by suggesting that they could *reduce* the doses as much as possible due to the side effects. He thought that the maximum desirable effect could be achieved with much smaller doses than some of his patients had used. This meant that the symptoms of illness would be increasingly present and that symptoms of side effects would be weaker. He also stressed that this did not imply that he was negative to drug treatment because the use of medications significantly improved the situation for the patients. When a patient expressed the wish to quit using drugs, he answered: "Let us try reducing it first, and then we will see how it goes!" Another staff member recapitulated a case history:

> She stopped using the medications six months ago after expressing a sustained wish to avoid medications. She became more afraid, and withdrew to her room. After a couple of weeks, it was apparent that she could not cope, and we were concerned that readmission to hospital would be necessary. In the end, she was so afraid that she asked to start on medications again.

What exactly made her so afraid remained an open question. The staff member regarded the patient's anxiety as a part of the illness that once again became unbearable. It might also have been the fear of readmission to hospital that seemed unbearable, and that being on drugs at least was a situation that she could handle if it also meant that she could remain outside the hospital.

Another type of story emphasises ambivalence. Due to non-compliance, one particular patient was treated with an injection every second week. A staff member said:

> I decided to reduce his doses from every other week to every third week. He wanted, of course, to quit all the drugs, but I told him that we should try this at first to see how it went. After 14 days, he again started to ask for the injection, despite the fact that we had agreed on every third week and that he himself wanted to stop all together.

The staff member suggested that it was partially the habit and partially the fear of what would happen when the effect of medication decreased that caused the patient to want to continue the medication as earlier.

Patient ambivalence was often an issue in staff narratives about drugs. Although a patient may have felt troubled by the drugs, they could still be seen as a safety net:

> [Patient] is willing to take higher doses that I find necessary and justifiable for him. He is so afraid of relapse, and he sees the high dosage as being on the safe side. I try to convince him that he will not get any additional effect from the higher dosage.

It should be added that this patient complained during interviews about the medications he was given. He suffered from the side effects and expressed a clear wish to reduce the doses because he was of the opinion that he received more than he could deal with. If we are to combine these conflicting pieces of information, the willingness to choose the symptoms of treatment said something about how much he feared the experience of the illness and what he was willing to undergo in order to avoid it.

The second-hand perspective on how necessary medications are was summed up in the question of whether it is possible, or even desirable, to live without drugs. The psychiatrist answered thus: "Medications are *necessary* and *preferable* because a life without medications will be so much more difficult for the patient." This line of questions arise as an alternative to the pro et contra of medications, viz. not how to live without drugs, but *in what way is it possible to live with the symptoms of treatment.*

Patients who have said that medications have been helpful still underline the importance of a therapist they can depend on and who listens to their opinions. The vicious circle of non-compliance is a struggle to regain a type of control that the patient is denied because of non-compliance. Concordance means making control a joint responsibility: An immediate advantage is that dropping or reducing drug usage may then happen as part of an open dialogue and not as something the patient may obtain by 'underhand' means. Furthermore, it means an environment in which the patient not only gathers first-hand experiences, but also has a qualified dialogue partner to consult. In addition, patients remain more in control of their own situation, which is perhaps a bigger issue than medication in itself.

6. SEEKING A NORMAL LIFE

6.1. Outer and Inner Perspectives of Rehabilitation

It was often difficult to know exactly what to think about the experiences from the visits at the unit. These experiences included incredible and sometimes terrible stories, as well as unfamiliar events and activities. Unusual ideas and behaviour were not something that could pass unnoticed, and more importantly, it proved difficult to remain neutral. The situation demanded that I choose how to perceive these expressions. The narratives of the patients were nothing like a masquerade or trickery. They were sincere and demanded to be taken seriously. As a rule, I tried, therefore, to assume that the patients meant what they said or did, even when things did not seem to add up.

Although peculiar events took place, I soon became accustomed to them as just a part of life on the unit. However, being accustomed to them did not mean that the difficulties were easy to come to terms with. These types of narratives and actions could not simply be ignored. The issues were always present as a disturbing element or source of potential conflict. Moreover, the decisions that were made could reveal another set of problems. Even staff members with extensive practice mentioned both general problems, and referred to concrete incidents in which they found it difficult to decide what to believe or do about a particular patient.

The staff members wanted to be flexible about the needs, opinions, and expressions of the patients. This was part of the treatment regime. We can call this 'the open attitude' because of its orientation towards the standpoint of the patients. It also included openness towards the competing theories within psychiatry (eclecticism).

The *attitudes* towards delusions among staff fell within the dialectic of two opposite positions. The first and traditional position was marked by the opinion that one should *'orient the patient towards reality'*. It was based on the notion of delusion as 'false belief', which reflects the opinion that delusions are confused ideas with little root in reality. In practice, it meant denying the story of the patient and correcting it in accordance with a 'common' or more credible perception of reality. In many cases, this was seen as a natural and even a humane thing to do. Arguments in favour of correcting the patient often mentioned situations (case stories) in which patients had been afraid, were likely to get hurt, or were likely to harm others because of their delusions. Moreover, differences of opinion usually mattered. It might be natural to correct or contradict the stories. As in other contexts, it is not natural to accept or smooth over *everything* you hear from another person. This is not the way one usually relates to disagreement. Nevertheless, there was a sense of discomfort among the staff. Some of them searched for another way to deal with the patients. Their concern was whether one ruled out the opinions of the patients simply because they were patients and thus made autonomy problematic. This latter attitude toward delusions was articulated as unease with the 'reality orientation' model. The position rested on the opinion that delusions might express something genuine about the patient that could not be expressed in other ways.

The conflict between these attitudes could take the form of either-or, as if a particular situation called for a particular perspective. For example, it might be comforting for a patient with anxiety to be assured that there is no need to worry. Other situations could be more ambiguous. It could be difficult to know how to respond other situations might even call for elements of different approaches. What is real may not always be clear. Consider, for example, a case of someone suspecting that they are under surveillance. There might not be any microphones in the room, and it is perhaps unlikely that anyone should pursue the patient. The question of surveillance is not an empirical problem. If a persecutor was suddenly revealed, the facts would change the perception of the idea. If it were an assumption that was made on inadequate grounds, it would be only coincidental if such were true. There would be no plausible reason why anyone would monitor the patient, so there is no *need* to look for microphones.

Then again, patients committed to institutions are, in a way, correct in assuming that they are under surveillance. They discover that staff and other patients know exactly what they have eaten, or how they have slept, or whether they have left their room during the day or at night, etc. Is it unreasonable to suspect that the staff, among others, also knew and kept track of other and more secret aspects of the patient's life? It was true that everyone knew almost everything everyone did, even though there was less control on the rehabilitation unit than at the hospital. There is therefore a core of truth in the paranoia. It is also difficult to decide what is true in perceptions like the following:

> Patient: "They did not like me back at the [Name of institution]. They treated me differently from the other patients. The others were greeted with a smile, while they were grumpy towards me."

Even if he was incorrect, which means that they liked him at least as much as they actually liked the next patient, the statement is still an expression of the perception of exclusion.

Finally, several staff members regarded rejecting the attitudes, values, or religious beliefs of patients as difficult because of respect for the distinctive character and autonomy of the patients. Some staff members also emphasised that rejecting the stories might make it more difficult to relate to the aspects of the stories that revealed self-perception and genuine descriptions of the patient. A story might be understood as disclosing aspects of the character of a patient even if it was not regarded as true per se. Sometimes even the most incredible stories were utilised, for instance, when staff talked about the background of a patient. The stories were often told as characteristic anecdotes about the patients. However, this often became complicated, and the staff frequently discussed how to relate to some of the stories patients told. Although many of the staff members wanted to accept as much as possible because they held the general attitude that patients should be able to express themselves, there were frequent discussions concerning what to do about particular expressions and situations. One patient, for instance, with an extraordinarily rich fantasy life, often spent his time telling stories that involved himself in first person. This caused the staff some concern because the narratives referred to historical incidents that took place centuries ago. The patient explained this inconsistency by saying that he was born in the 15th century. One particular effort to challenge him ended in a discussion about his date of birth and his age. The staff member said: "I don't understand how you can be that old. People that were born in 15th century cannot live today." The patient said that that was only true in her time, but not in his time. She followed up by asking what this date of birth meant in her time, and he gave a date which she confirmed to be his actual date of birth. She was of the impression that he actually could turn from one calendar to another, and that he perhaps operated with different notions of time.

Another staff member felt a similar dilemma in relation to the same stories. He felt that he, somewhere along the line, should stop the patient because he was uncertain whether the narrative was told as a story or as something that had actually happened. He did not stop him though, because…

> He is an excellent narrator and the stories are interesting and thrilling, and I am somewhat curious as to how they will end. Thus, I let him carry on.

Since there was generally an open attitude to patients' stories, it was easy to become accustomed to thinking of the patients in terms of these stories. This was possible partly because the problems of credibility also became familiar. None of the staff expressed any radical attitudes towards delusions in either direction. Rather, their attitudes were a form of eclecticism, which meant that one tried to utilize and relate to both points of view without having to choose between them. On the other hand, and more interestingly, the opposites could create considerable frustration because of having to *reject* both positions.

The open attitude tended, nonetheless, to collapse in encounters with relatives, the hospital, council offices, or other people who did not accept the content of the stories or self-characterizations of the patients. Their reasons for not accepting the stories were often well founded and understandable. The staff then ended up in an intermediate position. They could see why the environment reacted as it did while, on the other hand, they also understood what the patient meant and saw their perspectives as both relevant and descriptive. The staff tended, however, to support the patients in these meetings and to argue their cases. This was primarily because they found it relevant to do so, but also because nobody else supported the patients. Consequently, they were accused of being 'too much involved' with the patients, and one staff member responded: "Maybe we are!" This leads eventually to the collapse of the second attitude.

I want to suggest a third position in which one *wants* to take the narratives seriously, but *cannot.* Taking the stories seriously implies regarding them as adequate self-expressions, which created problems in relating the stories to the understanding of the network around the patients. The challenge, which led to a collapse of understanding, was how to mediate the difference in opinions and perceptions of the same situations and contexts. This third position indicates the need to formulate *why* understanding collapses and *what* is implied in taking the expressions of the patients seriously. We need to find a common ground between the 'outsider' and the patient.

6.2. A normal life under abnormal circumstances

The experience of walking in and out of the rehabilitation unit made me feel that I was *travelling between different worlds*. I think any newcomer experiences something similar because everything that we regard as ordinary is put to the test or changed. The first impression is that the institution almost exists under a different set of rules, or no rules at all. However, after a surprisingly short period, one becomes accustomed to the place and its people. The contrast or differences are not necessarily overcome, but one becomes familiarised with this *different world.*

On one occasion, several things happened almost at once. The events took place in the main living room. I was talking with two students who were at the unit for the first time as extra help. We were joined by a woman who told us about her royal duties and how she governed the world with the aid of a world council. When she had left us and returned to her room, another patient entered and sat down with us. She wore two sets of glasses, both reading glasses and sunglasses on top of each other. She wore long woollen underwear and a worn-out thick woollen jumper, but no pants. She was in an excellent mood and started to chat as if there were nothing unusual about the situation. Actually, there was nothing unusual about it. Even though I had already become somewhat acquainted with her, it was still difficult to avoid being distracted by her glasses and the way she was dressed. Was she testing us? Was she making fun of us? Did she like to dress like this? The students commented later that it was strange. On the other hand, it was true that we were in the common area of an institution that was also her home. Is it that strange to walk around partially dressed in your own home?

Then a third person started arguing loudly as if addressing someone. He stood in the kitchen area when he became increasingly agitated and ran out of the room yelling loudly at someone. One of the more experienced staff members calmly followed him. She explained as she passed us: "Sometimes he and his voices disagree, then the discussion may become a bit loud". She said this in a way that indicated that this incident was the most natural thing in the world; moreover, it turned out to be just that. Almost all of the psychotic patients have reported at least once that they had heard voices, and sometimes they answered or related to them as to an actual person standing in front of them. As a newcomer, I was not alone in not knowing how to take all these events. Even the experienced staff members did not always know exactly how to react; there was no standard procedure. But of course, the staff had extensive experience with the way things had worked before.

How to deal with patients' voices was often discussed among the staff. Although auditory hallucinations are one of the hallmark symptoms of schizophrenia, the voices vary from completely harmless to extremely troublesome. It is problematic when the voices cause the person to do things that harm him or herself or others. For instance, when I was serving in the army in 1996, a soldier threw himself in front of a machine gun during a live firing drill. Fortunately, he was not harmed. He later admitted that voices had commanded him to act as he did. He said that someone demanded this sacrifice of him or else his family would get hurt.

The voices may be annoying and rude. They may audibly express one's worst fears, point to one's weakest points, or criticize and offend both the patient and the people about whom she/he cares. A staff member described how he usually dealt with this:

> If somebody talks to their voices, one might comment on those things that one understands. One might for instance say: 'I see that you get angry. You sound angry now. What is happening?' The patient may then say: "The voices said that you were a devil." "That is awful", I would have answered then. "Do they really claim that I am a devil? Why do they think that?" I would in a way try to go into it, and most likely I would get an answer that the voices say so and so. Then I would say: "But this is not true, and you should not pay attention to the voices anyway. They try to trick you all the time." I would also add: "I really think it is your imagination that is playing a trick on you."

It is interesting that the psychiatrist in this case sketched out an approach that is similar to how you would react when people pick on you, except for the last remark. Still, there was no reason to disregard the event even if it was regarded as a figment of the patient's imagination. It is, of course, a question of *who* is picking on you in the case of hallucinatory voices. The voices are perceived as *not* belonging to the one who hears them; at the same time, they might articulate the worst things or fears of that person. The Psychiatrist's point is that the patient actually hears voices and responds to them as he would when people are talking to him. Seen from the perspective of the patient who hears the voices, it is not at all strange. From an outside perspective, however, reacting to hallucination by answering will be interpreted as unmotivated and disconnected from the context.

These examples also touch upon the question of how people may live *with* the symptoms of disease. Several staff members pointed out that other patients have managed well in spite of the presence of symptoms. Such narratives of success concur with a couple of qualitative studies focusing on the relation between recovery and symptoms of disease. Romme and Escher claim that the way in which a person manages to live with voices, is more a question of how the person deals with the voices than the character of the voices themselves or the fact that they hear them (Romme & Escher, 1989). Topor indicates in a pilot study that only a few former patients experience total recovery, but that many experience social recovery. This means that despite the presence of symptoms, patients are able to lead a (relatively) normal life and to function in society (Topor, Svensson, Bjerke, Borg, & Kufås, 1998). Topor indicates that other factors than the presence of symptoms of disease are better indications of both positive and negative turning points.

The aim of the treatment on the unit was not exclusively to do away with the *symptoms of disease, but more generally to improve the quality of life for the persons involved.* This meant that a wide range of factors, such as social network, practical skills, personal identity and security were equally important. Symptoms of disease were not seen as insignificant, even though their absence was not regarded as necessary for rehabilitation. On the other hand, it was regarded as imperative that one learned to deal with the symptoms. Recovery depended, then, on factors ranging from psychologically, the society and to practical demands. The everyday notion of 'normal life' is of course challenged. Such a model enforces the notion of *normal* life as being oneself, or allowing self-realisation as an alternative to normality understood in the light of what is typical and ordinary.

This also means accepting a right or need to be eccentric in order to be healthy. The differences between the life of the patient and that which is generally accepted behaviour, would also raise the question of tolerance and prejudice in society at large. However, the outsider perspective is different from the perspective on the unit. In practice, it meant that prejudices and fears of the patients in the society make a huge impact in the patients' life. It came to concrete expressions like the way many of them refused to call for a cab or enter a café simply because they have been denied access so many times that it seemed pointless to go on trying. These reactions were not necessarily connected to anything they did or to previous episodes, but simply to their unusual appearance. A staff member pointed to instances of what he regarded as cases of discrimination:

> Cabs refuse to take them on board. Either they think that they are intoxicated or that they have mental problems. Sometimes the cab just leaves without as much as an explanation. The patients experience this as degrading. When we are downtown, we often go to a restaurant or café. We usually persuade the patient to enter first. On one particular occasion, the patient was harshly stopped at the door. I then stepped forward and asked what seemed to be the problem, then he said: "Oh! They are with you! Ok, come on in then."

It is quite clear that common opinions about mental illness make life more difficult for the patients. However, even if the problems are caused by prejudices and are therefore unnecessary, it is still impossible to overlook the reality that such views matter. People are in fact afraid, whether their reasons are justified or not. One staff member explained why he thought the public was reserved:

Staff: The patients are perceived as odd, and then people think that they must also be unpredictable. Unpredictable people are capable of doing anything, thus they can be dangerous, and that they might kill them. This is generally the line of thought.

I: What features make people perceive them as odd?

S: It is primarily those features that make it difficult to establish contact with them, and those features that make them look different.

When you become familiar with all their eccentricities, you start seeing other qualities in the patients, and even the strangest features of their illness become 'normal' and even irrelevant. From the insider's perspective, other people's reactions appear to be unnecessary discrimination grounded in different appearance or behaviour, even though the behaviour was perceived as a problem with which it was possible for the patient to deal.

> It is actually possible to train them. A former patient became conscious of being well dressed, and started to trim both his hair and beard. From being an untidy and sloppy down-and-out type of man, he became a nice, respectable man with a beard. From being very restless and hastily wandering along the walls of the houses in the city, he started to walk more slowly, and thoughtfully, even though he was just as wildly mad inside, heard just as many voices and had the same old odd conceptions. He did also talk aloud with himself, but less than before. (…) It is clear, though, that he seemed much, much less crazy after a while. He was calmer and looked more common.

The contrast became obvious not only for those who came in from the outside, but also when one had to relate to people from outside, whether strangers or acquaintances. One staff member mentioned her reactions to a patient who had chosen a new set of parents. The parenthood was then passed over to yet another family.

> We kind of wonder how we are supposed to understand this, that he didn't belong to the parents that he has had, and that he has chosen new ones. In a conversation with a sibling of his, he was shown a picture because we were talking about his childhood and the things they used to do. He had some very pretty pictures from his time at school. He also had a funny newspaper clipping, which he commented: "This is my mother". The sibling became very angry, because it was a picture of a celebrity, and said: "I don't want to hear about it". I [the staff member] felt helpless in the situation. It was so difficult to say anything that could lead the patient to feel himself understood in that situation. How can I communicate this, when he himself has chosen an entirely new family?

In some way, both the rejection of the patient's original family and his reattachment to a new family made sense to the staff member. It was also my impression that they grew accustomed to thinking of him in relation to this imaginary family. True or false, it represented an important aspect of his *self*-understanding. On the other hand, the staff member could understand the sibling, too:

> It was clear that he did not want to listen to what the brother had just said. He said that it was impossible for him to talk with his brother because it was so upsetting to get their home life so disturbed in return.

The staff member found herself in the middle, *seeing the importance of both views*. Both stories made sense, and yet she found it impossible to keep moving back and forth between them. Each aspect made sense on its own terms, but it was difficult to relate it to anything else. On the one hand, she understood the sibling. On the other, life as it had developed for the brother was too cruel for anyone to bear. It would be almost callous to constantly remind him of it.

6.3. Dialectic of the trivial

When I give an *example,* it points to more than just a particular incident. The necessity in presenting examples is that there are aspects that are better displayed in their particularity than in general terms. For instance, when we speak of anxiety and inability, the anxieties and inabilities will always find concrete expression in trivial and particular events such as 'not being able to take the bus', 'not being able to travel to Svalbard', or the soothing sensation of alcohol. Moreover, when we speak of hallucinations, we refer to experiences and perceptions that may be described as 'peculiar things' that happened, or 'evil things hanging in the walls'.

We interact when we speak in such language-games. We use and respond to each other's words by listening, reacting, and answering. In such inter-play, an interaction manifests itself as the conversation evolves. The interaction is then placed in terms of a *trivial* model for understanding. The interaction that occurs as a result of the conversation may manifest a fundamental co-existence. The conversation opens up a shared space for the participants. They share that which the conversation is about. It is shared, not because we assume that the participants have an identical understanding, but because both parties relate to it and play along by responding to each other's utterances.

This kind of interaction or response, however, does not necessarily mean that the parties understand each other. The point is that the interaction plays on what is actually said as it is perceived. Both persons respond to the expressions of the other, and as such the expressions are directed towards each other.

A patient who is institutionalised has also been placed in a context that has been emptied of most of the elements that are essential to everyday life. Trivial activities are removed from everyday duties and activities. It is an extraordinary setting and it is intended to be extraordinary. However, several patients and staff members described the hospital as a place where there was little to talk about. In a certain respect, the institution represented 'a language laboratory' from which the trivial and ordinary actions and events had been removed. One staff member continued by sharing the very interesting claim that it was only at the rehabilitation unit that he really had began to *know* the patients. While he had met them in other settings at the hospital, the difference was that there was suddenly much to talk about. The reason was that the patients were concerned with everyday activities.

During the process of rehabilitation, the trivial and everyday are *reintroduced*. What is interesting about this is not only that a horizon of problems is reintroduced for the patients, but also that the new situation also offers a genuine hope of understanding them. Rehabilitation is a situation in which staff members are faced with another human being, even though the staff must try to comprehend everyday experiences that are very different from their own. Reflections and descriptions of the illness may easily divert attention from the trivial aspects of the suffering. Although schizophrenia contains many extraordinary and abnormal experiences, chronic suffering means, in this context, that the *extraordinary* has become *everyday* experience.

Trivial aspects of life initially became problematic; lack of ability to deal with everyday matters and fulfil vital goals were important reasons for the hospitalisation. Although the problems may have been related to trivial matters, somewhere along the line, the problems assumed such proportions that it constituted a crisis: The person could no longer attend to himself, and the network saw that it was necessary to intervene. Intervention will often mean hospitalisation that, among other things, implies a withdrawal from the trivialities and ordinary activities of everyday life. As the head psychiatrist said about the hospital: "It is sometimes necessary to secure basic needs, like food, housing, clothing, and security for the patients". He also described hospitalisation as a place to 'rest'. The argument emphasizes the patient's relief in being taken care of and not having to worry about everyday matters. Rehabilitation, on the other hand, reintroduces the trivial, and thus risks reintroducing patients to familiar sets of problems.

The renewed contact that the staff credited to the rehabilitation process did not revolve around major issues, but around questions like: "How do you make pancakes?"; "How have you decorated your living room?"; and "How is it normal to react during a funeral?". In other words, the personal contact between staff and patients revolved around trivial, accidental, and context-dependent concerns. Consequently, staff members found it easier to share their own experiences and be more personal with the patients. The context that made this possible were the things they had in common, something to talk about because the talk was connected to *something that both parties shared*. The examples dealt with trivialities. The dialectic of the trivial is therefore that it becomes inescapably problematic at the same time that it becomes the patient's rescue because it builds a bridge to understanding, interaction, and thus integration.

Philosophy has traditionally undermined everyday language because it lacks the precision and agreement of a technical and/or logical language. *Tractatus* accentuates a technical language as a paradigm of language: Precision and exactitude are essential for expressions to be meaningful (Wittgenstein, 1922). Expressions stand in a clear relation to the world; expressions are meaningful both because the relation between expression and fact, and the logical relations between the utterances themselves, are clear. When the later Wittgenstein turns his interest towards how words are used in order to explain 'how words mean', he simultaneously turns towards everyday language as essential in order to account for understanding. Meaning does not have to be decisive and unambiguous in order to be understood and be meaningful. Wittgenstein claims for instance that an utterance as "Stand roughly there!" makes sense, because the utterance makes *clear* what it refers to even though it refers to an *approximate* position. Wittgenstein claims, on the other hand, that although the example is of an utterance that is not decisive and unambiguous, there are clearly some conditions that will not be in accordance with the utterance while others will be. It makes sense, although the grey zone is not eliminated. Russell found these ideas of Wittgenstein problematic and comments:

> His theories are certainly important and certainly very original. Whether they are true, I do not know: I devoutly hope not, as they make mathematics and logic almost incredibly difficult (Monk, 1991:293).

Wittgenstein quotes Frege on the idea that every assertion contains an assumption. This implies that every assertion can be written in the form "It is asserted that such and such is the case". The criticism is first, that the words "it is asserted that" play no role in the utterance and second, that the sentence itself is a way of speaking and thus part of a language-game. There are countless numbers of different kinds of sentences, and this multiplicity is not something fixed. Some language-games become obsolete and forgotten, while others come into existence.

A language-game is part of an activity, or a form of life, and language-games will therefore arise, change, and disappear (Wittgenstein, 1958b:§23). The meaning of words is therefore rooted in the context in which they are expressed; that is in any imaginable activity, and understanding has to do with participation in the language-games.

The personal contact that was described as the result of everyday chat. The role of trivial chat in our setting suggests a deeper and genuine potentiality for social contact, and stands in contrast to evaluation of everyday language as a superficial relationship to both other persons and philosophical/existential questions. Everyday language thus is worth a closer look. The first task is to look into the collapse of meaning and the concept of illness. Then it is possible to look into how the trivial setting may help us establishing a hope of genuine understanding.

PART II:

BEING A DELUDED PERSON

1. OVERTAKEN BY DELUSION

Delusions became an inescapable and striking first impression at the rehabilitation unit. It occurred as awareness that *something* clearly was wrong or unacceptable in what was said and done: something did not add up. Delusions have been explained in the context of understanding – or rather 'incomprehensibility' and *not* understanding what the patient says. One question is whether incomprehension comes because of delusion, or whether it defines what we mean when we talk about delusions. Another question is how incomprehensibility contributes to an understanding of delusions and how we deal with such utterances.

1.1. Dealing with delusions

I was inescapably faced with delusions already from the beginning of the fieldwork. The notes from the fieldwork occasionally involved some very peculiar situations. It was puzzling that the extraordinary character of the situations often seemed less striking when the events later were recorded in a field journal. The situations were rendered in detail, and yet it proved difficult to give an exact account of *why* the situations stood out as wrong or unacceptable. This indicates a disparity between the *initial, clear awareness* of facing delusions and the recapitulation of their *content*.

It was often easier to grasp the reasons for their beliefs or actions once one became better acquainted with the patients. They usually did state *reasons* for their opinions or actions when asked, except in cases where these were too personal; though, a need for privacy is understandable, too. However, the narratives usually were understandable in light of their perceptions of the world. The lack of understanding could be due to difficulties in seeing what the world looked like from their perspective, or realising what the premises of their opinions and intentions in fact were. Sometime one could clearly say that the patients were mistaken; and yet, dealing with delusions was not as simple as the initial awareness suggested.

The stories were usually rational and understandable. Some stories were both interesting and excellent examples of storytelling; others could be remarkably accurate anecdotes or personal accounts. This was especially apparent when the stories later were written out in the field journal. When recapitulating the narratives, I aimed at repeating them on the premises of the story. At this stage and context, it was not necessary to question the premises of the narratives. This offered me the freedom to perceive the information as 'stories', and to recapitulate the information given in them on the patient's premises as far as possible.

The process of writing transforms the story from the *first-hand narrative* of the patient to *my second-hand narrative.* Although I aimed solely at reproducing the stories of my contacts, the stories are now mine. It is therefore important to be aware of the possibility that the narratives stood out as incomprehensible because I did not grasp the intention or premises in what was told. The process of working with the stories thus enforced my seeing the imbedded connections and associations of the narrative.

On the other hand, it is not adequate to claim that I added rationality, continuity, and coherence in the reconstruction/recapitulation process. The stories that are recorded made sense prior to the process of writing them down, although the picture didn't have to be clear after the first meeting. The connections refer to what the patients said. If a topic did not make sense, it could be clarified during the next meeting. Writing not only makes understanding conspicuous, it also reveals the author's lack of understanding. .

Jaspers describes an initial inclination to search for error in what the patient says. It serves to substantiate the immediate perception one gets when facing delusions (Jaspers, 1963:97). One assumes that the patient must somehow be mistaken or hold false beliefs. In other words, the patient does not check the assumptions in a manner that we would expect. The patient thus loses footing in rationality, and may develop a worldview that is disconnected and isolated from reality. Although Jaspers does not reject this approach, he also maintains that it does not gives an adequate account for the phenomena as such. Jaspers furthermore emphasises another aspect of psychosis that he regards as more essential than possible errors. He calls it 'a delusional atmosphere', which is a general elusive self-perception of the situation in which the patient finds him or herself.

When describing delusions in terms of error and false belief, it is likely that one thinks primarily of utterances like "I am an empress", or "There are microphones in my room", or again of certain characteristics ascribed to oneself and other people. It is problematic to evaluate features like certain actions, values, personal characteristics, and perceptions of anxiety, eccentricities, or irregular religious and moral beliefs in these terms.

To claim that a value is false, one must have solid reason to do so beside its content being unconventional or unfamiliar. One thus has to decide what *adequate reason* means before demanding that the patient account adequately for his or her opinions. This is not straightforward. Values *might* stand in relation to facts that can be disproved, but not necessarily. It is crucial not to loose sight of the fact that when meeting a patient one is relating to another person who tries to understand and express him or herself in an honest manner, even when it means using stories and explanations that are difficult to account for in terms of empirical, biographical evidence. A story can be very expressive apart from the question of its truth-value.

This is actually not very different from our own situation when we try to account for who we are. I can account for the more trivial facts, like my age, height, and educational background. Nevertheless, this would not only be a superficial self-presentation, it would also be insignificant and have limited value in stating 'who I am'. On the other hand, is it so that we cannot account for the most important aspects of life?

A possible grey zone does not undermine the search for error. The main reason to label any expression as delusional is based on an elusive, undefined perception of error. The elusive perception of error would form an *expectation* that the patient in further conversation will eventually express and maintain one or more clearly false ideas that will substantiate the initial perception of error. This additional discovery settles what the various expressions are, and may explain the more vague and ambiguous parts of the narratives of the patient.

Delusions constitute a context that has consequences, not only for the perception of the narrative, but also for the individuals who tell them. This context constitutes a horizon of understanding that fixates a certain way of understanding what is said. The context may then become an obstacle to understanding.

It is possible that we do not understand because there is nothing to understand. The problems of understanding can be due to a *pathological condition* that produces ideas without roots in reality. On the other hand, it is also possible that we do not understand because we do not *expect* that there is something to understand, which creates a hindrance to understanding due to the manner in which we relate to the patient. It becomes easy to rule out too much. The most feasible approach is to look into how these two approaches toward delusions interact when we try to relate in understanding ways to a deluded patient.

1.2. Jaspers on delusions

Karl Jaspers is an important contributor to describing the notion of delusions. His approach establishes a two-fold position in *General Psychopathology*. On the one hand, he describes the traditional approach to delusions in terms of understanding and false belief. He says that delusions can only "manifest themselves in judgement". He continues by saying that delusions are held with *"extraordinary conviction"*, and that they are "*impervious* to other experiences and to compelling counter-arguments", and that "their content is impossible", that is, bizarre or cannot be true (Jaspers, 1963:95-96). Jaspers argues that delusions are developed and altered from the time they arise:

> After the creation of the primary delusions from his experiences, the patient often takes a *further step*, and *holds on* to his delusion as truth. (…) He does this with a conviction far beyond normal, even perhaps stamping down on any occasional, initial doubt he may have himself (Jaspers, 1963:104).

On the other hand, Jaspers sees delusions in a direct relation to, and as an expression of, the suffering and the extraordinary experiences of psychosis. In one sense, he clearly rules out understanding delusions. In another sense, we may ask whether he opens up to a meaningful aspect of delusion as *expression of an elusive set of experiences,* and that it is incorrect to disconnect the expression from the experience.

Jaspers divides delusions into two groups. One group is understood in terms of preceding experiences like hallucinations (delusion-like ideas); the other group is for us 'psychologically irreducible' (delusions proper).

> With every hallucination proper, a need is experienced to regard the hallucinated object as real. (…) But should the patient, although such a correction is feasible, retain his false judgement of reality in spite of the known objections, in spite of reflection and with absolute certainty – overcoming indeed any initial doubts he may have had – then we are dealing with delusions proper: such a belief is no longer understandable in terms of hallucinations alone. With delusion-like ideas that originate from hallucinations, we only find a tendency towards false judgment of reality (or a quite transient certainty) but with delusion proper all doubt has ceased. (Jaspers, 1963:96)

Jaspers then refers to different hypotheses that may account for delusion proper. The first hypothesis denies that there is any *extraordinary* experience in delusion proper. It is rather an awareness of change in one's personality. This may be much like putting on a uniform for the first time and feeling conspicuous. A paranoiac will think that the change is in him or her, and that the environment also notices it. Jaspers maintains that we can understand some delusions in this manner, but he claims that this model fails to explain the essential nature and special character of delusions.

The second view maintains that delusions may emerge from any kind of experience and that this is caused by a lack of critical capacity due to poor *intelligence.* Intelligence is elsewhere characterized as the individual's totality of abilities for adaptation to life (Jaspers, 1963:214). This would indeed connect delusions directly to the ability of the individual to deal with life, and thus identify them as markers of illness. Even so, Jaspers abandons this possibility, although he admits that, "we tend to look for logical errors and blunders in order to prove such weaknesses," He does not see any direct correlation between intelligence and delusions.

> Actually we find every degree of mental defect without delusions of any kind and the most fantastic and incredible delusions in the case of people of superior intelligence. (...) The critical faculty [intelligence] is not obliterated, but put into service of the delusions. The patient thinks, tests arguments and counter-arguments in the same way as if he were well. (Jaspers, 1963:97)

Jaspers assumes instead, some specific alteration of psychic function, and not a failure in intelligence. He does not pursue a third suggestion of a singular *phenomenon* of delusional experience that defines the essence of delusion. Jaspers doesn't say what this basic primary delusional experience might be. The first two views are referred to as having some explanatory value; the third is in practice omitted.

Instead of searching for an underlying essence, Jaspers turns toward the manner in which delusions are manifested. The understanding of the phenomena of delusions depends on seeing them as expressions of the patients' intentions, thoughts and sensations. Jaspers thus goes further in exemplifying and characterizing different types of delusions. The first distinction in the field of delusions is what he calls "diminished awareness of Being and of one's own existence". Then there is "hallucinatory vividness", which is related to false perceptions and which only plays an accidental and relatively minor role according to Jaspers. Moreover, delusions imply "a transformation in our total awareness of reality" which also includes reality-judgments.

> If we try to get some closer understanding of these primary experiences of delusion, we soon find we cannot really appreciate these quite alien modes of experience. They remain largely incomprehensible, unreal and beyond our understanding (Jaspers, 1963:98).

Jaspers thus states a clear resignation with regard to understanding delusions even as meaningful expressions of an elusive condition. He however indicates that the patient also may possess a similar resignation toward the possibility of introspection and self-understanding. There is something going on and the patient is aware of this. Everything may have a new and different meaning even though perception is unaltered. It seems like something is in the air for which the patient cannot account. Jaspers suggests that delusions may arise from the distrustful, uncomfortable and uncanny tension that occupies the patient. He calls this perception "an atmosphere of delusion".

Jaspers regards it as unquestionable that the situation is unbearable for the patient, and that the patient suffers tremendously under it. He suggests therefore that the articulated delusions are a reasonable effort for the patient to come to terms with this uncanny and vague atmosphere. The situation is "beyond understanding and empathy" for the patients, and yet Jaspers can understand that reaching *some idea* will relieve the individual from some enormous burdens. Delusions are seen as an effort to comprehend the incomprehensible. He recognises the need and says, "Whenever we find ourselves depressed, fearful or at a loss, the sudden clear consciousness of something, whether false or true, immediately has a soothing effect" (Jaspers, 1963:98).

A focus on despair in the experience of the patient is an advantage in the *phenomenological* approach of Jaspers. The desperation is the context of the question "why does a person fall back on such vocabulary?"

Although he states that delusions are beyond understanding and empathy, he makes it possible to view delusions as meaningful expressions of a situation and set of experiences that exceed the *mere symptom* of disease. It is perhaps surprising how far he goes in illuminating delusions in meaningful and explanatory terms in order to describe the illness. He understands delusions as *expressions of suffering* and as a response to the situation. Delusions become a possibly adequate response to uncanny experiences that by themselves might be beyond articulation.

1.3. Faced with unacceptable premises

The narratives from fieldwork were written down in the field journal. This made it possible to review my own perception of the situations. To focus on the content of delusions became a dead end, at least when it came to the problems associated with *understanding*, and delusions as *marker of illness*. Moreover, the aim was to recapitulate the patient's self-identity, experience, and worldview. The need to validate their statements was only secondary. On the other hand, while recording what they said, the statements could make sense in such a manner that it almost caused the 'madness' to evaporate. This would not have posed any problem if it had not been in opposition to the initial impression.

I was once drawn into a debate that soon involved half of the patients at the unit and none of the staff. It started when one contact, knowing that I was a philosopher, asked me what I knew about communism. She was sceptical about the communist ideology and solution for the world economy and wanted to hear what a philosopher might think about that. Another person started to play with the word communism, making rhyme and associations with other words like capitalism, Nazism etc. Yet, another yelled out inarticulate, angry words. At the same time we discussed Marx, Lenin, the fall of the Soviet Union, and the USA. The discussion engaged one philosopher, at least two persons who ruled the world, one angry man, one poet, and one listener. The backdrop for this dialogue was how to rule the world properly, which the person that started the dialogue took as a personal responsibility. After recapitulating the dialogue, the remark "pure madness" was written at the bottom, to which my mentor responded after reading it: "I cannot see the madness anywhere in the text, which strictly speaking, discusses communism." The situation stood out as absurd there and then, and still did when it was written, and yet the objection makes sense. It is impossible to pinpoint exactly why this should manifest 'pure madness'.

I was sometimes uncertain about *how* to understand what was said and done, as well as knowing what to think about the patients' explanations of events or opinions. It could be difficult to see their reasons, especially when the content of their stories, for some reason or another, were doubted.

On the other hand, consider the statement "I am the ruler of the world"; what is hard to understand about this? Which part is especially absurd? Does it express unfamiliar words? Of course, you may say, "… but she isn't!" However, in order to *reject* the statement, it is presupposed that you know exactly what is being said independently of what you regard as facts. Although it is understandable, it is also unacceptable or impossible to enter the premises it presupposes.

We are drawn into the context of the patient in a manner that makes it impossible to keep a distance to the statements. It was particularly difficult during the fieldwork, when I was drawn into or included in the narratives myself. On one level, it could be quite trivial, such as when someone tells something about me. The best example of this was an incident where a patient greeted me and started to talk about what we had done on an excursion that I never have attended. I told her that she perhaps confused me with someone else. She became irritated and told me not to mess with her. I was then no longer simply a spectator, but also a participant. The aspect of participation made the problem immediate and unavoidable. I did not have to say or do anything to position myself. Simply by being included in the narrative, I was inevitably drawn in and had lost any possibility of neutrality. If I was to answer, I had to either play along with her or deny what she said. Suddenly there was no polite or satisfying way out.

This reveals an interesting dialectic within the hermeneutical situation. Gadamer works out the hermeneutics put to use on texts. He argues that the preconditions for understanding imply that we *take over the premises* on which a text is written. This does not necessarily imply agreement, but rather an ability to look at it from the other's point of view (Gadamer, 1975:277ff).

The experiences of being drawn into the narratives would of course establish the basis for the hermeneutical situation of understanding instead it triggered a counter-reaction. By being drawn into the narrative, one was faced with having to play along with premises that stand out as unacceptable. The hermeneutical approach will then be invalidated even before it has started, resulting in an inclination of the spectator to withdraw from the narratives with their complications for participation and understanding.

1.4. Psychosis and incomprehensibility

Markus Heinimaa argues that use of the concept of psychosis, due to its connection to delusion, marks the very limit of our psychological intelligibility (Heinimaa, 2000). His argument rests on a grammatical interpretation of psychosis in which it is seen as a technical term with a clear connection to the everyday concept of madness. The question is in what manner psychosis and madness are used to express the perception that something in what the patients said did not add up.

In some instances, we do not understand what was said due to accidental reasons. I might say that I do not understand a person because she uses words I do not know, or that her speech is too inarticulate to be understood. However, I then assume that her utterance might be restated or explained in a way that I could understand. In that case, that which she says isn't incomprehensible.

Heinimaa maintains that the use of the concept 'madness' shows that it necessarily implies a lack of understanding. The way we use 'madness' in everyday language may even state the reason for not understanding, viz. we do not understand because there is nothing to understand. There is therefore a grammatical concurrence between "I cannot understand it" and "It is madness". For instance, I might say that I do not understand her because she is mad. This implies that I cannot understand her because she cannot be understood at all. It is to be taken as the consequence and articulation of the elusive perception of madness as something that does not add up.

Madness may be applied to account for oneself. I could consider skydiving as madness. Some skydivers even regard it as madness themselves – it is in fact madness in every aspect of the word to jump out of an airplane, isn't it? Still, it is something they like to do. It remains difficult or perhaps even unnecessary to state reasonable arguments to support the statement, 'I like to jump out of an aircraft'; the reason is better left open.

Heinimaa regards 'Psychosis' as a *technical* term that is based on the *everyday* concept of madness. This means that its basis in 'incomprehensibility' is present in the use of concepts like 'psychosis' and 'psychotic' because of its relation to the similar uses of the everyday notion 'madness'. According to Heinimaa, psychosis states the reason for *not understanding* another person. Alternatively, we call it psychotic because it is incomprehensible. To state that something is psychotic corresponds to saying that it cannot be understood. 'I cannot understand her. She is psychotic.' This means that I do not understand because it cannot be understood at all. The ordinary concept of psychosis hence negates the possibility of understanding due to the way it is used. Trying to understand psychosis is then a contradiction because it can only mean that if I do understand the expression then, per definition, it is not psychotic.

The strength in Heinimaa's argument is in pointing out the continuity between technical and everyday language. Although the analysis of the everyday term 'madness' is interesting, the analogue to psychosis is questionable. It is perhaps true that psychosis is the paradigm of madness; however, madness entails much more than psychosis. It is also incorrect to say that incomprehensibility is part of psychosis in the manner Heinimaa does. Incomprehensibility is perhaps a part of delusion, and thus becomes a part of the definition of psychosis. It is important that psychosis isn't an everyday concept. Its usage is meaningful within the context of psychiatric diagnostic classifications of DSM-IV/ICD-10. Perceiving a phenomenon as psychosis is based on its expressions as a health problem. Delusion and hallucination are markers of psychosis within the DSM-IV system. It is consequently more than the question of self-insight that marks the difference between the technical language and the everyday concept of madness.

Although the technical term introduces another perspective, Heinimaa argues that it continues the tacit perspective of not understanding from the everyday usage of the term madness. Of course, he could refer to an analysis that the technical concept of psychosis implies incomprehensibility as it is used by personnel to describe their patients; however, he would not then need the reference towards the everyday concept of 'madness' in the first place. Heinimaa thus prioritise the everyday language and indicates how the technical term reflects common usage.

The aim of Heinimaa in reflecting on everyday experiences with psychosis is to place 'I do not understand' as a reaction to expressions that are experienced as meaningless in the situation, or perhaps even as wrong or harmful. He reflects on a peculiar and yet conspicuous aspect present in encounters with psychotic persons. His purpose could entail the manner in which the technical term 'psychosis' is formulated in response to this elusive, everyday perception. The diagnostic language thus becomes a reflection and explanation of the experience of not understanding.

However, to claim that 'not understanding' is the result of, or inevitably connected to psychosis, would actually contribute to fusing the link between psychosis and non-understanding. The traditional view of psychosis is sufficient to fulfil the premise that when we use the phrase 'psychosis' or 'psychotic', it implies that we do not, or cannot, understand its expression. This does not necessarily mean that it is impossible to understand the psychotic *patient* as such. It only means that if the patient starts to *make sense*, we will call it something other than psychosis, like 'clear moments'.

The problem with Heinimaa's argument is that he substantiates the traditional tendency to rule out delusions as meaningful expressions, instead of looking at the potential that they provoke. In favour of Heinimaa, one could claim that he is only investigating the actual usage of the terms, and not the phenomena itself. The way we use the concept could be misleading, but Heinimaa does not suggest this. The advantage is to illuminate important implications of the initial perception of madness as *beyond understanding*.

This comes at a cost, because if Heinimaa is correct, it implies that the hermeneutical premise, which is understanding, is surrendered or made obsolete when we face madness or psychosis. This can only imply that the project of understanding psychosis, and of approaching the main features of schizophrenia, is a priori doomed to fail. The psychotic expressions should consequently be left as they are.

However, there is a difference between stating that problems of understanding are part of the experience, and to claim that the concept signifies lack of understanding. 'Not-understanding' has not only received a too central role, but the question as to *why* we do not understand, is left open. It is therefore necessary to go further into 'how words make sense', and if possible to clarify what goes wrong when trying to understand delusions.

2. BREAKDOWN OF UNDERSTANDING

The patients in the unit could occasionally withdraw into what we might speak of as a 'private sphere'. They talked to themselves, were secretive about their doings and opinions, or simply abandoned contact with others. Although withdrawal could be seen as part of the illness, it could also be seen as a reasonable response to the frustration and resignation connected to not being able to communicate with others. It is therefore not viable to omit the way we deal with expressions of psychosis when speaking of the isolation that is associated with the condition.

What is it that makes us perceive certain manners of expressing oneself in action and words as deluded? How do our perceptions and attitudes towards these phenomena affect the understanding of what is being expressed? It has to do not only with what psychosis is, but also with the attitude that spectators have towards psychosis. The description calls for a clarification of the context in which the phenomenon belongs, and the manner in which it seizes and draws both the patients and spectators into this setting.

2.1. An Autobiographical Case History

Some of the residents in the rehabilitation unit frequently engaged themselves in what may be described as monologues. One person sat in a common room telling a story aloud. He often did this, and he did not mind the audience. However, he got angry when people addressed him regarding the story. He obviously did not want to be interrupted. Yet, he answered other questions about his meals or apartment without any further ado. He continued the story where he left it when he had finished answering these questions. He repeated the story to himself regularly. Sometimes he could continue the same story for several days, further developing it in each repetition. He did not seem to mind that people were listening. Another example was the situation where a patient occasionally would sit on his balcony yelling at the world. He got particularly loud when people passed on the street below or on the lawn. Although he sometimes yelled *at* them, it was not always the case that he addressed anyone at all.

On another occasion, a patient entered the main living room talking angrily with himself. He seemed to be looking for coffee, so I offered him a cup. He answered by snapping verbally at me. He then ended the conversation and walked away still yelling, but not at me anymore. He continued to talk with himself even more loudly, more quickly and far too inarticulate for me to understand him. He was enraged, but I could not understand why, or even comprehend what he said to me. I felt sad because I did not understand him, and because my intention to be nice somehow resulted in my making him very angry. A nurse spontaneously explained that he often made complaints that people do not have any respect for him because they do not listen to what he has to say. She said that they have told him that it sometimes can be difficult to understand him simply because he speaks too rapidly and indistinctly. He still disagreed and said that people *do not take time* to listen because they *lack respect* for him and that which he has to say.

Once, when I arrived in the late afternoon at the rehabilitation-unit, I met an employee whom I had not seen before. I assumed that she was extra help on the unit. I then introduced myself and told her that I came from the university. I told her that I studied this unit as a part of my research. I realised immediately that she mistook me for a patient and probably thought that my idea of doing research was delusional. At once, it became crucial to clear up this misunderstanding. I therefore informed her about the scholarship and a little about the project. She listened, but at the same time, she started to fill a bucket with water and left the room to clean the windows. I followed her outside still explaining my work.

Gradually I became aware that I had started to behave like a patient *trying to convince* her of something that she *did not believe* anyway. I stopped talking. It was, however, difficult to leave the situation still suspecting that it was not clarified. I was somewhat confused regarding what I should do so I decided on a pragmatic approach: I had permission to be there, although I most likely was not in a position to clarify this at the time. I assumed that as long as she mistook me for a patient, she would at least not call the police to have me thrown out. I decided to re-enter the main living room and talk to the patients, as was my usual practice. It was very relieving to meet an elderly patient who recognized me and asked how I had been. This grounded me and brought me back to a sense of normality.

The most frustrating part of this experience consisted in *not being heard, or even, not being able to make sense*. In one way the employee must have understood every word I used, and yet she must have *understood* my words as an *expression of an illness* and not of my genuine intentions or actual endeavour. When I attempted to clarify by adding and elaborating details, it did not change her view at all. Still, I thought that if I only gave her enough information and could explain the matter clear enough, she had to understand that I *really did* belong to the university. On the other hand, she had no *reason* to change her view of what I said. I realised that everything I told her could be part of an elaborate delusion. As long as she perceived me as delusional, it did not matter what I told her. Moreover, I was not able to change the context in which she understood what I was saying.

2.2. Losing the means of communication

Rush Rhees argues that words have meaning because it matters what we say. "What we say makes a difference. The expressions we use make a difference" (Rhees, 1970:55). Expressed in another way, if it does not matter what I say, then there is no point in my talking at all. The words are then reduced to meaningless sounds.

A psychiatrist referred to a case in which the police brought a man to the hospital. He had just reported to the police that someone was planning to kill him, but the police felt the need for a psychiatric evaluation. The psychiatrist listened to the story and entered a dialogue with him trying to see what he meant:

> How do you know that someone was planning to kill you? – I can hear them talking between themselves. – Where do you hear them? - In my office, at home, in the park … - Is anybody else present? - No, but I can overhear them anyway! - How is it possible that you hear them in the park? - They connect via the Internet.

The entire story of being in danger may stand out as delusional. We may even agree with that, so that relating to it as delusional makes *what* is actually being said secondary. Consequently, the police do not have any good reasons to look further into the matter.

What he actually says doesn't really matter. It simply would not make any difference whether it was a group of *students*, the *police,* or the *mob* that were trying to kill him. It would not matter whether they tried to kill *him*, his *wife,* or *themselves*. It would not matter whether they tried to *kill* him, *rescue* him, or *reward* him. Regardless of which concepts he chose, it could still mean the same, viz. as an expression of delusion. The expressions used would make no difference. Speech that is met in this manner conveys no meaning. As one patient put it, "You try to tell them something important, and nobody listens. They only say 'Yes, and aha' and ask questions about my medication".

My experience of not being understood lasted only a few minutes. There were no pathological reasons for that, but the situation of being excluded was a reality. What if one had to live in that situation for the rest of one's life, as might just be the case for persons suffering from schizophrenia?

2.3. Enforced monologue

It makes sense for patients to withdraw from others as long as it does not matter *what* they say anyway. Regardless of what the patients say, they might always be understood in the same way – apart from what they actually say. If nobody listens or understands, the best option may be to sit on a balcony and yell at the world, or perhaps remain completely silent. This is a kind of *forced solipsism* because the withdrawal is not voluntarily. Solipsism is an assertion that there exists a first-person perspective possessing privileged and irreducible characteristics, in virtue of which we stand in various kinds of isolation from any other person or external things that may exist. Louis Sass claims that the schizophrenic patient's withdrawal is so strong that it implies a solipsistic position. This explains the seemingly irrational or bizarre features of the schizophrenic mind. It thus stands out as a problem to itself because of rationality (Sass, 1994).

Although the perspective of Sass is interesting, the claim that one is being *forced* into a solitary situation indicates an aspect of the isolation that is unnecessarily inflicted by others. It somewhat depends on how we deal with these utterances, in addition to the 'inner', pathologically explained withdrawal and problems of expressing oneself adequately. It is therefore essential to look at how this isolation of the patient occurs and the possibility to break or dampen the isolation enforced by social conditions.

Wittgenstein pursues the subject of speaking of inner experiences. Understanding is described in terms of interactivity and a shared language. Moreover, he treats monologue as a special way of speaking, but neither as a *private language* nor as a *limiting case* of language (Wittgenstein, 1958b:§243). Wittgenstein refuses the possibilities of a meaningful, private language; however, he sees neither *monologue* nor *being alone* as this kind of privacy. Talking to oneself is in fact a way of speaking and hence a form of language. It does not correspond to the *solitary speaker,* for whom talking to himself is his primary (and only) language.

Language presupposes *the other* person due to its connection to speaking and understanding. It is easy to find examples of monologue. One could, for instance, give oneself an order, encourage oneself, blame oneself, or punish oneself. Talking to oneself is just one possible use of language. In some cases, one could even speak *aloud* to oneself and it would be quite normal. I may for instance rehearse what I want to say, or I may walk alone in the forest singing a tune. The problems connected to *private language* are not connected with speaking to oneself. Wittgenstein continues:

> We could even imagine human beings who spoke only in monologue; who accompanied their activities by talking to themselves. – An explorer who watched them and listened to their talk might succeed in translating their language into his own. (This would enable him to predict these persons' actions correctly, for he also hears them making resolutions and decisions).
> (Wittgenstein, 1958b:§243)

The other person is not necessarily absent from monologue. I could, for instance, let other people know what I am thinking by expressing thoughts aloud to myself in a manner in which the monologue is used as a literary effect. The thoughts of a character may be expressed in the form of a monologue in a play. The *audience* follows the actor while *she* speaks to *herself.* This aspect was present in the "storytelling" patient: Even if he did not want any participation, he possibly had an audience.

A monologue is language as long as it communicates. It does not exclude that others may understand. The language is not private in the sense that it prohibits others from understanding what is said. Even though the person is talking to him- or herself, others may follow the thoughts while they are being expressed. The form of monologue that Wittgenstein describes in §243 of *Philosophical Investigations* is thus still communication; the private languages in the continuances are questionable. Speaking to oneself does not exclude the possibility for others to understand. Even the case in which I do not understand a single word could still be communication. It is like being scolded in Italian or another language you happen not to know. You get the picture although you do not know what is being said. The isolation is a definite problem when, for one reason or another, nobody really listens when they speak.

The cases where the patients and I spoke by addressing ourselves to others, do not really qualify as monologues. In fact, the frustration caused by these situations is best understood as an attempt *not* to enter a monologue. One is trying to make the other understand what one *means,* without being able to do so. We were forced into the position of being 'solitary' speakers, even though the problematic is reversed. If it does not matter for others which words I use, their sounds are without meaning. Therefore, I speak a meaningful language and use words correctly, but that which I say has no meaning because my words are not *received* as meaningful.

This is also the case with the man's reporting the plot to kill him. The problems of relating literally to *what* he said, doesn't mean that he doesn't say it correctly or that he uses words and sentences incorrectly. The problems of understanding are not explained by the expression of delusion, but that what is said is not received as meaningful. The premise of hermeneutics is thus disregarded.

Others might deprive me of a language in this manner. I am not withdrawing from others. I am being *excluded* from being with others. This creates a profound loneliness that is perhaps impossible for one to understand before he/she is deprived of the possibility of sharing a language. One is then thrown back into a situation where speech may only be directed toward oneself. The other possibility is silence.

2.4. Attitude towards Understanding

How do our attitudes and expectations of delusions affect understanding? It is not a matter of course that what a person says makes sense or is true.

These considerations, however, do open an interesting concern regarding the dynamics of the hermeneutic experience. Gadamer claims in *Truth and Method* that understanding involves taking over the premises to which the text belongs. It does not presuppose agreement, only the ability to assume the other's point of view. Differences are not seen as a problem, but rather as a potential for understanding. Inability or unwillingness to assume the situation of the narrator, on the other hand, eliminates understanding as an actual possibility. The attitudes towards the patients are essential elements because they play a part in constituting the sense of reality and world. This does not mean that the context alone constitutes the problem. It cannot be seen in isolation from the pathological situation. This is true even though normal expressions of thoughts and intentions might be caught up in this setting and increase the impression of elusiveness.

This is the context of being mistaken for being a deluded person. This incident was perhaps a marginal case, in which something supposedly normal is taken for deluded, but also illustrates how a person can be overtaken and captured by the context. One might think that since the situation of being deluded was available to me in this particular setting, everyone may have this experience. However, this illustrates merely a possibility; it says little about the generality, or what is usually the case. On the other hand, one would say that the perception of me as patient was based on a *mistake*. That is, it was taken as deluded, but this actually was not the case and therefore it really is not about delusions. This is based on an assumption that there is something special with these people, or that it is their descriptions and expressions that make them deluded. This situation delimits delusions from normal self-accounts. The next step must therefore be to look at delusions in connection with the expression of illness.

3. DELUSION AND ILLNESS

The traditional view is to emphasise delusions as false, or as beliefs that are inadequately founded. The description of the variation and complexity of the experience of delusion has been criticised as insufficient. Is it possible to relate to the patient in an understanding manner and still maintain the special character of delusions as a description of illness? To answer this, the reformulation of the question as to *how* we understand and *what* is understood is a more productive approach than asking *whether* understanding is possible. By describing the situation as an example of understanding, the aim is to investigate not only the phenomenon of psychosis, but also the limits of understanding.

3.1. Illness and health

It is common practice to let 'illness' denote the *experience,* and to let 'disease' denote the *causal* aspects of being ill. Even though the perspectives are independently defined, it is difficult to avoid the discussion as to which is given priority. The traditional approach is to see the experience of illness as a result of the situation caused by disease. 'Illness' is thus seen as subsequent to disease. Several authors account for illness in terms of intentionality and thus relate it to different theories of action and/or personhood.

Wiggins & Schwartz argue that the main classificatory manual (DSM-IV) does not speak of disease, but of disorder. They maintain, however, that the concept of disease can aid in structuring the field, in addition to functioning as a guiding idea in investigating mental disorders. Karl Jaspers's groups of mental illnesses illuminate the benefit of such classifications. The problem is rather that "... when we attempt to formulate what we do know about such illnesses, we must conceive them, as well as almost all other mental disorders, as ideal types" (Wiggins & Schwartz, 1994:103). As ideal types, they allow us to express our partial unawareness and partial knowledge of mental disorders. "Because of the arbitrariness of ideal types, they can be employed as polythetic concepts, prototypes, or dimensions, depending on one's psychiatric purposes" (Ibid). This opens to diversity within the field of psychiatry;

however, they also think that psychiatry achieves its systematic unity in a manual that classifies most mental disorders as ideal types. It justifies maintaining psychiatry as a *medical speciality*.

Mishara argues from the phenomenological point of view that we need a different concept of disease to approach the meaning of disturbance in the *subjective experiencing* of the patient. He maintains the necessity of a theory of human subjectivity which allows him to account methodically for the subjective experience of the patient that goes beyond the commonsensical assumptions that uncritically inform other approaches (Mishara, 1994). The task is therefore to look into a concept of disease that entails the diversity of the phenomena, and yet demarcate mental disorders in such a way that it has explanatory value that may serve as a guiding idea both for research and treatment.

Lennart Nordenfelt, on the other hand, approaches the concept of illness by clarifying the concept of *health*. Health is accounted for in terms of action. He deals with health in terms of ability and disability and is especially attentive that health must be seen at different levels. This problem is particularly conspicuous with regard to handicaps and chronic illness (cf, Nordenfelt, 1987:36). In order to avoid potential contradictions in a conceptual grey area, he argues that health must be seen as a *minimum condition*, which is sufficient to fulfil the vital human goals. This must, moreover, be seen in relation to the normal circumstances and abilities of the individual (Ibid, 46ff, 79). He thus articulates a definition in which health is explained:

> A is healthy if, and only if, A is able, given standard circumstances in his environment, to fulfil those goals which are necessary and jointly sufficient for his minimal happiness. (Nordenfelt, 1987:79)

His main interest is, on the one hand, to oppose the *naturalistic model* that takes disease primarily to be a question of causality and disease as denial of health. On the other hand, Nordenfelt opposes the *quality of life model*, which reduces the question of health to a matter of well-being. He also intends to gainsay the initial understanding of health as being a question of excess powers or reserves.

However, is it actually plausible that one would experience this *minimum* condition as being *healthy*? Imagine if a person had sufficient ability to achieve vital goals but nothing more. Is it likely that this person would experience oneself as a being in a terrible condition? Following Nordenfelt, we could say that health understood as a minimum condition recognizes the inclination that health only *becomes an issue when health has become problematic*, the ability to fulfil personal goals has been compromised, and particularly if continuance of life is made difficult or impossible.

Health does not presuppose 'well being' (quality of life) or absence of disease (naturalistic model); instead, it is seen in relation to the self-perception of the person involved. This will of course imply a relativistic understanding of health, because it is dependent on personal, subjective goals. On the other hand, a possible answer may be that we really are not that different from each other when it comes to the vital goals, which is the issue here. For obvious reasons, illness will influence the health of the individual; still the action-theory of Nordenfelt opens up to the simultaneous presence of both illness and health, which is particularly relevant to chronic conditions.

Does this imply that schizophrenia is to be seen as an illness? Schizophrenia represents a condition that severely delimits the ability of a person. The anticipation of getting well is almost absent. Health has clearly become a problem. However, in what sense is it *illness* in the terminology of Nordenfelt, or rather is the schizophrenic patient healthy? Is schizophrenia 'un-healthy' in the sense that it deprives the person of the ability "to fulfil those goals which are necessary and jointly sufficient for his minimal happiness"?

The main reason for intervening (even compulsorily) is based on the assumption that due to schizophrenia, the abilities of the person to take care of his or her vital goals are seriously compromised. So far, schizophrenia stands out as an *unhealthy* condition according to the action-theory of Nordenfelt; however, he adds that the abilities of the person must be seen with regard to "standard circumstances in his environment", which includes social fellowship. Within the social fellowship, family, assistance, sympathy, and even public health care become factors. As an illustration, one staff member expressed the possibility of dealing with schizophrenia apart from medical treatment:

> It was easier before, when the schizophrenic could follow his father on the boat until the father could not control him anymore. Today, there are more requirements for security courses and technical education, so it is harder for the schizophrenic to fulfil social expectations.

The coping strategies within a modern society are difficult. Social security, work programs, and even begging, stealing, or finding temporary shelter will serve to maintain life. The quality of life will most certainly be below average, but if the question of health is a matter of minimum requirements, the primary question must be whether the patient is able to maintain vital goals like food, shelter, and clothing. Still, it is not correct to claim that the action-theory of

Nordenfelt fails to view schizophrenia as illness, or that it fails to view it as a problem with regard to health. A question is, however, whether he gives us reason to consider both aspects at once.

The rehabilitation program called for dialectic between health and illness. Success in achieving the goals of rehabilitation did not depend on the patient being free from symptoms or becoming 100% healthy viewed by the naturalistic model. The aim was to help the patient to deal with life in an adequate manner with as little help as possible within the available conditions. Rehabilitation depends therefore on an asymmetry between health and illness. In this context, health cannot be defined as a denial of illness/disease, or visa versa. The theory of Nordenfelt thus demonstrates an interesting aspect to the case for treating schizophrenia. A possible objection to the theory could be seen as its strength.

The *question of being unhealthy* is raised long before *the question of ability to care for vital goals* is actualised. It accordingly vindicates a reason to view the patient not only as ill, but also as being healthy. This overlap of health and illness will cause problems to any philosophy that tries to define either illness/disease or health as mutual contradictions. Every such definition seems to include cases that cannot be explained by the definition. Even simple examples may lead to trouble if the asymmetry is not accounted for. Diabetes is, for instance, clearly an illness. It will influence a person's possibilities and it will define risk for other conditions. However, a person may lead a perfectly normal and healthy life within the limits that the illness constitutes.

Svenaeus argues that health is better described in light if the phenomenology of Heidegger, and medical practice in terms of hermeneutics (Svenaeus, 1999). Intentionality, in Heidegger's terms, is always directed towards the possibility of continued existence. The world presents itself as meaningful only in relation to this possibility. Health has to do with ability to deal with everyday life, and illness is a factor that will hinder self-realization. This marks both an asymmetry and a connection between health and illness that opens the possibility that even a seriously ill person may enjoy good health. Health becomes a question of how one deals with the possibilities life presents. Illness is part of the delimitation of these possibilities; hence, illness has a direct effect on health and yet, it does not define health itself, even though it raises the perspective of the manner in which a person deals with illness.

Corresponding aspects were applied to chronic schizophrenia by staff members who participated in this study, by pointing at *how* patients managed to live *with* the symptoms of schizophrenia. Rehabilitation does not depend on making the patient symptom free; however, the patient must somehow be able to deal with the illness in an adequate manner. Although it is useful to view schizophrenia also in terms of health, the main problem is to formulate a clear understanding of the problems and why it must be seen as an illness.

3.2. Illness understood as action-failure

> "Willing, if it is not to be a sort of wishing, must be the action itself. It cannot be allowed to stop anywhere short of the action." If it is the action, then it is so in the ordinary sense of the word; so it is speaking, writing, walking, lifting a thing, imagining something. But it is also trying, attempting, making an effort, - to speak, to write, to lift a thing, to imagine something, etc. (Wittgenstein, 1958b:§615)

K.W.M. Fulford's main interest is mental illness. He maintains that somatic and mental illness must be kept apart as distinct sub-species of a generic concept of illness, though he envisages a continuous rather than categorical distinction between them. He furthermore refutes the mind-body dualism, but maintains that mental illness must be understood independently from physical illness (Fulford, 2000). He employs Searle's theory of intentionality as his point of departure in order to explain the difference and to work out an understanding of the concept of illness (Fulford, 1993b; Fulford, 1989). However, the most important philosophical basis is his reading of Austin and his linguistic-analytic methodology that entails a view of philosophy in general as a 'ground clearing exercise'.

The contribution of Fulford is to see *illness as action failure*. Furthermore, the reason why we perceive delusions in terms of illness is their character of being action failure. He does not attempt to advance the details of the argument. His intention is rather to set up the action-failure theory as a framework for further and more detailed study. In fact, he says very little about what failure of intentionality as illness may be. His arguments instead are directed towards showing that illness can be understood broadly in terms of failure of (a particular kind of) action. The question is whether this perspective may help us maintain a description of delusion as expressions of illness without excluding the possibility of understanding.

Why do we perceive certain situations in terms of disease in the first place? Loss of capacity or ability is, according to Fulford, taken as the leading concept for disease. Mental illness, on the other hand, is rather described as 'loss of control' or 'unable to resist' (Fulford, 1991:89). Moreover, he claims that the perspective of illness tacitly raises the more fundamental questions of will, freedom, and autonomy. He therefore maintains that the discussion of disease is already placed within a discussion of human agency and experience, and that the concept of disease becomes secondary to that of illness.

The concept of disease is an empty concept apart from the set of actual and potential problems it represents. In this manner, disease is determined by illness; that is, illness becomes the premise for disease. Fulford names his theory *'the reversed model'*, since it inverts the traditional relation between illness and disease (Fulford, Gillett, & Soskice, 1994). The causes of a condition are secondary, but important because they describe a way of *dealing with the illness* in order to try to re-establish the capacity of normal functioning.

It is possible to imagine situations in which one does not have any experience of being ill, but when it still makes sense to use the concept of illness. This may be the case, for instance, when an illness like cancer is discovered at late stages and a person might say in retrospect that "now I understand that I have been ill all the time." Although seen retrospectively, one thereby assumes that the illness has been there all the time, both as explanatory to problems that have been experienced, but possibly also independently of any experience of illness.

Action failure applies to a large range of problems outlined by the patients in this study as well. Anxiety may, for instance, directly interfere with what one wishes to do. Compulsory action has been described by some patients as experiencing an internal force against one's own will. However, may the same concept of action failure be applied to delusions in general?

Fulford suggests viewing illness in term of failure of action, and he considers this particularly relevant in relation to delusions. He argues that the diagnoses are (negative) value laden concepts (Fulford, 2002; Fulford, 1993a; Fulford, Smirnov, & Snow, 1993). Illness will necessarily be negatively laden since it is something unwanted or something that hinders the person in unfolding. The negative evaluation is therefore tacitly understood in the descriptions of the condition. Fulford's suggestions have caused debate around the concept of illness.

McKnight supports Fulford's view of illness as action-failure theory. McKnight discusses two examples, put forward by Fulford, and argues that the experience of illness is dependent on action-failure. He concludes, "[Experiencing illness] involves experience of an intention to act which is not followed by the appropriate action and there is no external impediment" (McKnight, 1998:196). He maintains that when there is *no intention to act*, the *potential action-failure* defines illness.

Eavy criticizes both McKnight and Fulford for separating the experience of illness from illness itself. He argues that their view would imply viewing illness in terms of incapacity, and that it will only be viable as long as action-failure is *experienced.* The consequence is that action-failure simply adds *yet another* aspect to the illness in addition to experience. Eavy argues that 'illness itself' is an empty concept if it is separated from the experience of illness, because "In the absence of this experience a condition of body or mind remains what it is, which is to say, for instance, a continuous pain or nausea or anxiety etc." (Eavy, 2000:296). He disagrees that it is possible to view 'illness itself' apart from the experience in the way that McKnight presupposes, without falling into *causal explanations* which belongs to *disease*.

He therefore concludes that the view advocated by McKnight is the least viable description of health available. It reduces the importance of personal experience for the understanding of illness. Eavy objects: "It is, after all, people that become ill, not bodies or bedposts" (Ibid). On the other hand, the holistic view of the person that Eavy asks for is in fact a premise to Fulford's action-failure theory. Human agency defines what we mean by being a person. Any interference with our ability to act will therefore interfere with the person as such. Therefore, the action-failure makes the experience what it is. The example of a paralysed arm is supposed to illustrate that. Regardless of what causes the paralysis, it will imply that I am not able to write or use my arm in other undertakings. In other words, the condition obstructs or delimits my ability to act. Hence, even a limited condition (like a fractured arm) will affect the person as a whole. Disease will view and describe the condition as a *part* of me; illness on the other hand affects me as a person.

Eavy does not comment on McKnight's understanding of failure in the relation between intention and act. Failure occurs when one intends something and the intention is not followed by the appropriate action. This might seem viable with regard to the failure of raising my arm. However, Fulford points out in *Moral Theory and Medical Practice,* that delusion, as the paradigmatic psychotic symptom, should be seen as constitutive rather then merely executive failure of action. Delusions are not only accompanied by actions, but will be better understood *as reason for action* rather than false or inadequately founded belief. Fulford still maintains that delusion represents action-failure and thus is to be regarded as illness. The failure occurs however within intentionality itself and not in that the act does not come about as intended. The argument against McKnight, but not Fulford, is therefore the manner McKnight separates intentions from the action.

Fulford, however, does not pursue in detail what the relevant kind of failure of intentionality might be. He concludes by noting that delusions may take the form of value judgements as well as the more familiar factual beliefs. Fulford's argument aims at showing, across a range of examples of both bodily and mental illness, that there is a correlation between the features of the experience of illness and the features of the phenomenology of action. The practical/clinical question of evaluating what is failure (and what is not) is then a matter of discretion and faculty of judgment and not an either-or situation as the notion of false belief allows.

The action-failure theory furthermore places the problem of illness in relation to human agency. It also represents a view of delusions as belonging to descriptions of illness, which means that psychosis is inevitably seen as illness. On the other hand, nothing conclusive has been said about understanding so far, nor have we said anything about the consequences of this perspective for the patient. The latter is mainly discussed by Fulford with regard to compulsory treatment, which also may imply that the possibility of understanding is secondary in favour of a question of self-insight and -control.

3.3. Action-failure and clinical judgement

In *Moral theory and medical practice,* Fulford employs the concept of action-failure in order to consider the need for compulsory treatment in dealing with psychosis (Fulford, 1989; cf, Fulford, 2000). The action-failure implies seeing the use of force in connection to protecting the person against oneself. This leads to Fulford's main interest, which is the value-laden nature of mental illness compared to bodily illness. He argues that the clinical practice and perception of delusion cannot be accounted for in terms of the traditional notions of delusion. Furthermore, he argues that his theory of action-failure is already a part of clinical practice.

His solution could therefore not be viewed as a rejection of, or alternative to psychiatric practice. It rather represents a clarification of the practice that is already at hand. The criticism is therefore that the traditional notions of mental illness fail to describe how we actually evaluate and perceive its expression of the experiences of schizophrenia.

Fulford justifies the action-failure theory with regard to delusions by referring to its explanatory value. He emphasizes the manner in which we account for actions and argues that a reason for an action may refer to facts or values. I turn my car to the right *because* it is the way to Oxford (fact), or I turn right *because* I need to go to Oxford (value). On the other hand, he understands delusion as "defective reason for action" (Fulford, 1989:216). For instance, there is a case where a patient explains his attempt to commit suicide because he regards himself as a horrible person, and this is grounded on the fact that he could not manage to give his children enough allowance: for this reason, they would be better off without him. His explanation is actually a reason for *action*, viz. his suicide attempt. What he says represents a reason that is difficult to follow, support, or participate in, but not because its line of thought is irrational or hard to understand. The rationale in delusions may be clear; however, they entail unacceptable premises that we (have to) reject. It can be self-destructive intentions, exaggerated negative or positive self-evaluations, and so on. This leads to Fulford's third moment, viz. that valuation by the observer is an implicit and essential part of experiencing something as delusion.

Furthermore, Fulford bases his theory on a concordance between *reason for action* and *delusions*. He claims that the reason for any action will be stated as accounts about *facts or value*. Not all factual or value judgments are reason for action. There is therefore a need for a supervening faculty that adds to the reasoning and constitutes intentions as reason for action. The failure that divides delusion from other reasons for action is then connected to human agency or intentionality and not our ability to understand them. Delusion as action failure touches the person as a whole. Failure regarding intentionality might then imply that a person fails in acting in accordance with one's own best interest.

3.4. Understanding and action-failure

The focus on intentionality has interesting implications that illuminate the subjective and private character of psychosis. Imagine how even simple things may represent different meaning depending on the situation. The world of the happy is very different from the world of the unhappy even if they share a household: so must the world of the delusional be. Imagine for instance the world of the paranoiac – how things that seem small and insignificant to us may be seen either as threatening or as proof of persecution.

What is delusional in terms of true and false becomes even more elusive when it comes to religious ideas or ethical considerations. If we take the concept of delusion to suggest something unreal or false, then we have to decide in what way beliefs and views of life might become 'unreal' or false. Delusion or not, beliefs tend to become an important part of a person's identity and explanation of life situation, therefore they will more or less determine how a person values and relates to the world and other people. In this manner, any belief (even a 'false' one) will participate in constituting how the 'real' manifests itself.

Understanding an action is connected to its intention. Intentionality can be approached on its own premises. It is possible to understand and recapitulate the reasons *why* the father tries to commit suicide without agreeing with him, supporting him, or supposing that one would do the same thing in a similar situation. Fulford suggests a concept of exaggerated negative evaluation of the situation as explanation for the action-failure in this case.

Fulford's theory implies that understanding can never be final. First, describing illness and disease depends on values, which focuses on clinical judgement. Second, the theory describes the reason why illness becomes problematic to the person involved and to the surrounding network. Third and consequently, the action-failure theory must be seen in relation to Fulford's intention of evaluating the need and legitimacy to intervene.

A potential problem with the theory is that it further substantiates the traditional notion that the patient lacks insight and the ability to account for oneself. For Fulford, this is not a problem with regard to the theory. His approach is the observation that, in whatever way we understand 'lack of insight'; it is a given part of what Austin would have called the 'logical geography'. It is a feature of the way we think about mental disorder that has to be either explained or, if we think it is invalid, explained away.

On the other hand, viewing psychotic expressions as actions implies that the action can be *understood* in terms of its intentionality. This supports the need to acquire the patient's perspective of the situation and the reasons for acting as he/she did. Understanding and meaning depends on inter-human interaction. There are thus two opposite movements regarding delusions. First, the perception of delusions as illness signifies not only the suffering and incapacity associated with schizophrenia, but also the negative evaluation of these features as something *unwanted.* Second, a profound relation is established in witnessing the expression of the other. This allows the person to be accepted as irreplaceable, thus confirming the individual as a person. These two aspects do not exclude each other. The way we relate to delusion illuminates both a context in which talking about inner states makes sense and a context in which it does not. For this reason, understanding a psychotic person is more a question of *how* one relates to the utterances rather than a question of the essence of psychosis.

The experience of being mistakenly put into the place of the patient was not because what I said or did was beyond understanding, or needed extraordinary skills to be comprehended. Furthermore, what I said was neither false nor impossible; still, what I said was written off and therefore deprived me of an interaction with the other by the means of language. The consequence was an inability to express myself. The reduction becomes possible only when one ceases to presuppose meaning in what other persons say. In a certain sense, what I said or did made no difference because I was written off as a person. It coincides with ceasing to see individual patients as persons. This implies isolation from others.

My experience stands in sharp contrast to the contact some of the staff had with their clients and the efforts that were made to see topics from the viewpoint of the other. This does not imply that every psychotic expression has meaning; that would be an allegation easy to falsify empirically. In addition, do we have to assume that every 'sane' utterance possess meaning?

Taking what the patient says seriously implies not only trying to see what the other means, but also expecting that what the other says has meaning. Taking it serious could for instance make sense as an effort to deal with *incomprehensible* experiences in a meaningful fashion. Despite Jaspers's descriptions of delusions as beyond understanding and empathy, he goes far in taking them seriously by viewing them as *expression* of suffering, or as a perception of reality that is beyond *clear descriptions* or *explanations*.

Is there room even within the traditional view to ask *what* and *on what grounds* we can understand these expressions of psychosis? What does it mean to be this person and to have these extraordinary experiences? What does it mean to ask who the person is and how he or she sees the world, himself or herself and fellow human beings? It was common for staff members, who have worked with patients suffering from psychosis, to accentuate the suffering of the patients. Suffering as such is thus a point that clearly is *not* beyond understanding. In fact, it would be hard to miss when speaking to the patients. On the other hand, it is interesting that delusions often are seen in relation to the suffering. It is valuable to pursue this further in order to see whether this kind of understanding of the situation of the other can help us see beyond a mere emotional reaction. Before we may ask how such a connection is established, we should look into how we account for ourselves and what this can reveal about the other.

The traditional approach has been to claim that expressions of psychosis are incomprehensible per se. However, following Fulford, it is more plausible to claim that the reason we perceive the patient as delusional is a matter of failed action and not because his or her utterances might appear irrational, unfounded, or false. In other words, we may understand what the patient means, and yet we cannot follow along the line of thought.

PART III:

EXPRESSION AND UNDERSTANDING

1. Facts and Values: Accounting for Oneself

We account for ourselves in different ways under different circumstances. ‘Understanding’ is therefore used differently in various contexts. In certain situations, it was almost impossible to assume *the standpoint of the patient*. How does this situation arise?

It is interesting to observe how we talk about experiences with patients in terms of ‘understanding’ when understanding as such becomes problematic. Understanding the other entails more than just comprehending what is said. It will also include aspects like seeing why a statement is held as important or ‘how it accounts for the person’. The patients couldn’t always explain or account for what they meant. However, should we see this in opposition to the manner ‘the rest of us’ account for what we believe, hold as true, or important? Is it true that some aspects of life cannot be accounted for in a complete manner?

1.1. Being certain and having reason to doubt

Rhees perceives ‘madness’ as a philosophical problem of certainty (Rhees, 2003:118ff). The term madness is often simply used in contradiction to reason in philosophical literature. A popular version of ‘delusion’ thus sneaks into philosophy in which ‘madness’ signifies lack of logic (rationality) or self-deception. It, therefore, defines what reason is *not,* or what it means to abandon rationality.

Oxford textbook of psychiatry connects delusions to ‘strong conviction’ and ‘unwillingness to accept counter-evidence’ (Gelder et al., 1996). It is a ‘jumping to conclusions’ that is not understandable or can be explained in terms of ‘cultural or social background’. It represents a way of reflection that differs from normal thinking. However, can we actually say that this designates delusion as phenomena, or does it instead point to the tacit inertia of any conviction and world picture? As discussed above, Jaspers maintains that delusion is not caused by lack of *intelligence*. The patient tests and argues, and thus employs reason in the same manner as healthy people do; nevertheless, the statements of the patients somehow are erroneous. Moreover, although it may be understandable how a mistake is possible, it is not always obvious why a person persists in the error against common sense and argument.

The topic of 'certainty' and '(reasonable) doubt' is raised explicitly by Wittgenstein in *On Certainty* (Wittgenstein, 1969). Wittgenstein argues that checking one sense impression with another, or securing right answers by calculating the initial error over and over again may bring the testing of an assumption into a circular argument (Wittgenstein, 1969:§77). If an error is systematic, then one could systematically repeat the same mistake. If the error is connected to perceptibility, could we clarify the mistake by testing one impression with another? His point is that when we account for ourselves, we must begin to trust our judgement somewhere along the line. Moreover, if I cannot trust myself in my judgement, why should I trust anyone else?

> The reasonable man does *not have* certain doubts. (Wittgenstein, 1969:§220)

> That is to say: somewhere I must begin with not-doubting; and that is not so to speak, hasty but excusable: it is part of judging. (Wittgenstein, 1969:§150)

There are aspects of philosophy that look like madness. It is not simply because philosophy questions the obvious, but also because of its tendency to *uphold the doubt*. The paradox is that philosophy *depends on a sceptical attitude*, and yet, it *cannot survive scepticism*. It simply doesn't make sense to doubt everything. We can doubt every single fact, but we cannot doubt them all (cf, Wittgenstein, 1969:§232). Examining everything will lead to an infinite endeavour that leads us nowhere. It is thus superfluous and nonsensical.

However, doesn't this endorse a fundamentally sceptical attitude towards knowledge and/or the world? Buchanan points to a tension within what Wittgenstein says about scepticism. Buchanan argues that the concepts on which "On certainty" rests, cannot be applied to the *common sense* propositions that the traditional sceptical arguments seem to undermine. Wittgenstein therefore does not confront scepticism, according to Buchanan; on the contrary, he wants to avoid scepticism by bringing its premises to its conclusion and in this way demonstrating it as unnecessary and impossible (Buchanan, 2000). Stroll argues that Wittgenstein only describes what we actually do and how *doubt* participates in what we call certain. He argues that Wittgenstein defends the possibility of certainty and thus rejects scepticism (cf, Stroll, 1994:138ff). Instead of undermining the language game of certainty, he claims that doubt is one of the features that defines the language game of certainty.

Moreover, being certain must sustain an awareness of the possibility of self-deception. Hallucination is a concern with regard to certainty. Wittgenstein discusses it in relation to sense impressions. Hallucination represents a *possible* explanation for a situation in which we cannot trust our senses. Hallucinations lack outer references, one hears voices even though there is no one there; they thus represent a possibility of confusion with regard to reality. Delusions, on the other hand, may be private ideas in the sense that nobody except the patient holds them. In this context, an aspect of self-deception or fundamental mistake is significant. The discussion of certainty assumes the possibility that we might be deceived by our senses and common sense; that is, we may be mistaken and hold on to the mistake. The question is therefore on which grounds one should start doubting one's own perception as well as when one should do that.

Wittgenstein refers to an example about *certainty* used by Moore: I see my hand in front of me and feel certain that it is a hand and that it is mine. However, how do I know that it is real and not a hallucination? Some patients report hallucinatory sensations that are so vivid and distinct that it is as if they are real. At which point should a person begin to doubt one's own eyes and ears and presume that what one sees and hears is not real? Moreover, if we cannot be certain of our senses and faculty of judgement, can we be certain about anything at all?

> What about such a proposition as "I know I have a brain"? Can I doubt it? Grounds for *doubt* are lacking! Everything speaks in its favour, nothing against it. Nevertheless, it is imaginable that my skull should turn out empty when it was operated on (Wittgenstein, 1969:§4)

> If someone is taught to calculate, is he also taught that he can rely on a calculation of his teacher? However, these explanations must sometime come to an end. Will he also be taught that he can trust his senses – since he is indeed told in many cases that in such and such a special case you *cannot* trust them? (Wittgenstein, 1969:§34)

Wittgenstein furthermore investigates a connection between the concepts 'know' and 'being certain': To *know* something is to be *certain*. To be certain means that I *cannot be mistaken*. The basis for knowing is thus to know that I cannot be mistaken.

> It needs to be *shown* that no mistake is possible. Giving the assurance **I know** doesn't suffice. For it is after all only an assurance that I can't be making a mistake, and it needs to be *objectively* established that I am not making a mistake about *that. (Wittgenstein, 1969:§15)*

Wittgenstein thus establishes an interesting dialectic of certainty. On one hand, much of that which may have explanatory value as to how mistakes and illusions may deceive us is taken for granted and not accounted for. On the other hand, there is the 'burden of proof'. That is the claim that one must account for *how* one knows (cf, Wittgenstein, 1969:§550).

> One staff member described an incident where he had entered a room were an elderly woman was sitting alone and yelling as if somebody was with her. She explained that there had been two

> children in the room, but that they disappeared when he entered. The children were rude to her because they didn't introduce themselves and refused to answer when spoken to. They just stared at her and did not say anything. She did not have any clue as to where or how they disappeared. They just vanished. (Field journal)

What the staff member found peculiar and unnatural was not that a person can be mistaken in this manner, but that she could go on maintaining that it was not a hallucination. Usually, people are in a room and then they leave. Persons do not vanish from one moment to another. However, is this sufficient to undermine one's own clear and distinct perception of actually having *seen two children*? How do we discover the illusion if the natural inclination is to trust one's senses? It was impossible for the staff member to assume the standpoint of the patient, although the story of the old lady was completely understandable as such. In addition, a delusion is a meaningful way of expressing oneself; its content is understood. However, its claim of truth was not acceptable. He said: "It simply isn't the way people communicate with each other."

How would you proceed to prove the deluded person wrong? The way is not necessarily straightforward even with regard to 'simple' facts because it isn't just a matter of what is at hand, but also what meaning it manifests, or *how* we perceive the fact. Even a 'neutral' happening, like skies that clear up, will have special meaning to a person that is not only predicting or observing the weather, but who actually is engaged in controlling the weather. Blue skies meant that he was successful, poor weather meant that he had to do adjustments. Even the happenings we think of as part of a natural weather system beyond our control actually have a place within his world picture.

Furthermore, a sour greeting in the morning can mean so much; among other things, it may substantiate the suspicion that this person actually bears a grudge against you. A meeting is never just two people who happen to pass each other; the meaning isn't unambiguous. The meaning of even a sour greeting can be a subject for discussion. On the other hand, it is possible that the person is oversensitive to negative signals. However, how would you convince the other that you, in fact, do not have a grudge against him? Can we convince him that he is wrong? We could perhaps smile or give assurances that we do not hate him. Would explanations like "I was only tired this morning and my throat was sore" be convincing? Nothing will count as *evidence*, although explanations could serve to *weaken* the perception of being disliked. When the pattern is sustained, it will increase the reason to doubt the initial opinion until it, if possible, looses its relevance.

Paranoiac delusion describes the perception that someone wants to "get you" when there is no reason to believe so. The suspicion is held as relevant by the patient, but not by the people around him. There is of course no way to prove the non-existence of possible pursuers, and there is perhaps no way to completely cancel out the perception of the relevance of such a belief. It is sufficient to advocate a notion of '*reasonable* doubt'. Reasonable doubt implies that one abandons one's claim, not because it is rendered impossible, but because one cannot substantiate it. Alternatively, we could consider the possibility, not as to how to *counter* the argument, but how not to *confirm* it.

One informant expressed different suspicions of persecution that, over time, merged indistinctively into each other. Although the actual content of the statements changed, other statements were more stable as, for example, the suspicion of surveillance. This suspicion was a general belief that staff members were engaged in some sort of surveillance. This is perhaps a belief that is *least reasonable* for a patient to doubt. Staff members do actually keep track of them. It is part of institutional life and the transparency of a small unit. For instance, one informant would never tell anything negative about the staff while being indoors. Instead, he took me outside where he reckoned we were *safer*. He could talk more privately and freely there. He said that he did wish to stay at the unit. He found himself in a situation that was better than that which he had experienced before at home or in other institutions. The suspicion of surveillance endured, although none of the persons he named worked at the unit at that time. This, however, did not prove that the surveillance had stopped. It could mean that it was organised differently. He also said that he must be careful because some of them might get a job where he was and could expose him again in the future.

Paranoia is interesting because it is directed towards facts; still, it is mainly a question of how these facts are to be understood. When it comes to religion or ethics, however, the aspect of evaluation becomes more eye-catching. How to understand what is believed in is a question, but there is also a question as to when we *'should'* start to doubt what we know or believe. What can the perspective of certainty versus doubt offer in the description of delusions?

not help us much because there is still something erroneous or unacceptable in this way of thinking. This latter assumption depends upon an evaluation of the meaning given to the facts and values. In other words, how can we be certain that we are correct in *our* assumptions?

1.3. Describing inexplicable aspects of life

Wittgenstein was interested in the special character of religious and ethical concepts. Ray Monk argues that religious beliefs were important to Wittgenstein. Monk argues that Wittgenstein could accept an expression of faith as long as he could connect some meaning to the expression, which means that it must have explanatory value (Monk, 1991:411). Monk raises also the question concerning which meaning (if any) Wittgenstein actually did connect to religious concepts.

The question is whether this could contribute to how we evaluate religious reflections. It is interesting to observe how the patients in search of meaningful concepts sometimes depended on religious language to express their experiences. Religious beliefs cannot be dealt with in terms of empirical validation. Wittgenstein regarded it as characteristic of *religious* or *ethical* concepts that they are 'unfounded'. They are essentially different from scientific concepts. This difference is not seen as a weaker claim about the world compared to empirical evidence, nor do religious and ethical concepts offer a mere play with words or senseless words.

This aspect of ethics seems to imply relativism, and yet, ethical statements emphasize certain claims about how to lead our lives; the claims are made in an absolute manner. It is therefore surprising how he accounts for ethical propositions in *'A lecture on Ethic's*. Wittgenstein portrays ethics, not in opposition to facts, but as another aspect of reality that cannot be accounted for in terms of empirical evidence (Wittgenstein, 1984:37ff; Wittgenstein, Ambrose, & Macdonald, 2001; Wittgenstein, 1967). This kind of language represents a form of creativity, in which we try to discover connections and meaning where our concepts and knowledge no longer can offer explanations, or when the explanations become ambiguous or irrational.

The examples put forward by Wittgenstein are bizarre: What would you say if you saw a mouse emerge from rags? Such an event couldn't be accounted for within a scientific conceptual scheme. You could search for the mouse in the rags or look for a natural cause for it to appear. One would most likely think that it was hidden in the rags. However, there is no way you can explain the mouse as emerging *from* rags. Wittgenstein lists a series of questions concerning how one would relate to and recapitulate experiences that are hard to place within an existing world picture:

> What if something *really unheard-of* happened? If I, say, saw houses gradually turning into steam without any obvious cause, if the cattle in the fields stood on their heads and laughed and spoke comprehensible words; if trees gradually changed into men and men into trees. Now, was I right when I said before all these things happened "I know that that's a house" etc.? (Wittgenstein, 1969:§513)

Such experiences would totally change the image one has of solid objects; however, it is also clear that empirically based knowledge does not account for such eventualities. We wouldn't expect this to happen. Nevertheless, regardless of how unlikely it may be, these or similar revisions of what we would expect can take place.

If you still wanted to state what you have seen, the description can only account for itself. You would have to settle with the mere *description* of the experience without explaining it. If we wanted to articulate such events, we would have to settle for the mere description, and yet, Wittgenstein uses belief to describe an essential aspect of knowledge. He thinks that even simple references to unambiguous, elementary facts and values will entail premises that are taken for granted. We must therefore reach a point at which we think it unnecessary to substantiate any further. Thus, the explanations remain open.

Moreover, the description of delusions as being in contrast to what is ordinary within a 'cultural and social background' could also be seen as the originality of a belief. This raises another aspect of understanding that exceeds the question of endorsement of the other's standpoint. Such reality-orientation stands in danger of confronting the belief of the patient with a *common* opinion of the facts. Furthermore, the most reasonable response to counter-argument is to defend one's own position and thus strengthening the positions of *both* parties. An opinion is not likely to be shaken by argument unless you have a *reason to doubt* your judgement. There is no reason to assume that you will surrender it simply by the counter-argument of the other. The question is then what might be sufficient to undermine the trust in one's own perception.

1.4. Accounting for what we know for certain

Wittgenstein investigates the use of knowing in *'On certainty'* (Wittgenstein, 1969). To know something is to be certain about it. The difference between the concepts 'know' and 'being certain' is of no importance. In certain contexts, they may also replace each other; for instance, in a testimony in a court of law to say: "I know that this is the case"; is the same as claiming: "I am certain that this is the case."

> For 'I know' seems to describe a state of affairs, which guarantees what is known, guarantees it as a fact. One always forgets the expression 'I thought I knew' (Wittgenstein, 1969:§12).

To be certain or knowing does not exclude *possible* mistakes; however, it does entail that "grounds for doubt are lacking" (Wittgenstein, 1969:§4). Being certain presupposes that we can account for the reason why we are certain. Wittgenstein continues:

> 'I know' often means: I have proper grounds for my statement (...) [The other] must be able to imagine *how* one may know something of the kind." (Wittgenstein, 1969:§18)

It becomes a matter of trust in the sources of information. For instance, how do you know the height of Mont Blanc? – My teacher taught me and I looked it up in a lexicon and both are reliable sources of information. The account is therefore not absolute or final, which means that it can be questioned.

On the other hand, there must be a good reason to doubt the grounds of knowledge before we reject it as certain. For instance, how do I know that this is my hand I am looking at? Alternatively, I could ask whether there is any reason to doubt my own eyes. Were lies the possible mistake for such a statement? Hallucination? When everything speaks pro and nothing contra to the evidence, we do not have any reason to doubt what we know. Doubting everything would not get one far. It is neither a 'sane' nor a possible option. "The game of doubting itself presupposes certainty" (Wittgenstein, 1969:§115). We could doubt every single fact; nonetheless, we can't doubt them all. However, would doubting almost nothing get one any further? Somehow, we must decide what it means to doubt too much and what it means to doubt too little.

Lars Hertzberg argues that trust is a basic attitude and that certainty depends on our faith in a world picture (Hertzberg, 1994). He says that we have reason to trust in the information and facts we perceive as long as they concur with the general picture. Moreover, a good picture proves itself everywhere; in short, we can work with it without doubting it (cf, Wittgenstein, 1969:§147). Facts that speak in favour of a world picture will increase the trust in it. It simply is not reasonable to doubt certain things.

To be in doubt means that I must at least know what would count as evidence and what would not. Because of trust in the world picture, it has an endurance and priority in relation to the simple facts.

> I believe that every human being has two parents; but Catholics believe that Jesus only had a human mother. And other people might believe that there are human beings with no parents, and give no credence to all the contrary evidence. Catholics believe as well that in certain circumstances a wafer completely changes its nature, and at the same time that all evidence proves the contrary. An so if Moore said, "I know that this is wine and not blood", Catholics would contradict him (Wittgenstein, 1969:§239)

In the picture of the Eucharist, perception does not count as evidence because it only reveals the existence of the wine, when it is the essence that is in question. The objection, "but it does still taste like wine", could be met by both views: "Of course it does, didn't you hear what we just said?" The object of faith is in that case untouchable to both logic and experience. This does not mean that it cannot be either correct or false.

The example of religious faith could of course be seen separately from the rest of the discussion; however, Hertzberg places Wittgenstein's reference to faith in connection to world picture and thus also his investigation of the concept of 'certainty'. The discussion of religious faith would otherwise be ill placed or might even be regarded as a counter-example of certainty because it cannot be accounted for in the same sense as empirical facts.

Trust is the basic attitude towards reality according to Hertzberg. We expect the world to be and behave in certain manners, and our perception of it is coloured by this confidence. Being certain doesn't rule out mistake; however, it entails the claim that we are able to account for why we have no reason to doubt what we know. We end with a dialectical concept of certainty in which certainty seems to both refute and endorse the fundamental doubt of scepticism. Wittgenstein affirms that we could try to give another person our picture of the world, but this will happen through a kind of persuasion (cf, Wittgenstein, 1969:§262). A compelling reason is a matter of trust, so the important aspect is therefore the role of doubt.

Is it possible to consider delusions in this manner? We could evaluate them as we would any assumption; the only difference is that the element of uncertainty, or what we take for granted, occurs more clearly for the onlooker. A concept of illness is difficult to connect to the manner we test sense impressions or opinions. On the other hand, the role of doubt indicates how strong convictions may be undermined, not by counter-argument, but by making them superfluous or irrelevant.

How can you say of *any* idea that it does or does *not* reflect reality? A religious belief, for instance, may sometimes offer possible meaningful explanations and a context for experiences in which they can make sense. The question of rejecting *religious* beliefs and values is even more difficult since perceiving a belief as delusional cannot be reduced simply to a matter of what we may tolerate. The patient may hold opinions that are shared with no one else; yet, it is not the originality in an idea that constitutes the idea as delusive thought. Delusion is determined by a concept of illness

We cannot exclude any possibility of a mistake even though we may maintain that knowing implies certainty. The patients accounted for themselves and for that which they held as true or important. They expressed themselves in a manner similar to that of other people; however, it sometimes proved impossible to assume *their standpoint,* as if they move along a path that we cannot follow. This does not necessarily mean that the patients follow a different grammar when accounting for themselves. However, the problem occurs as part of the interaction with the patient. The clue to why understanding becomes problematic may be found by examining our own tendency to withdraw from that which the patient says. What happens when we speak is therefore a crucial question to pursue in the following.

It was common for the staff to describe the statements of patients in terms of narratives. The concept of narratives was used at different levels, although the connection to life-story primarily came to mind. The concepts of narrative and story were also present in other connections. For instance, recapitulations or characterisations of a patient's story in the form of a 'case *history'*, accounts of trivial or significant happenings, or anecdotes all included elements of narrative and could be included in a narrative. The narratives were given much weight because they were seen as informative and as having explanatory value with regard to individual patients.

The emphasis on narratives has problematic aspects as well. First, it is not correct to perceive everything that a patient or staff member says as (part of) a narrative or story. Second, the reason for emphasizing narratives may also be a fundamental objection against narratives. The interest in the narrative is, after all, that which the story expresses about the person and not the story as such. We must look into the way narratives and particularly fictitious narratives, may constitute a context in which they make sense as authentic and truthful descriptions of a person. The question of credibility will therefore be important and especially so in the context of delusions.

2.1. Transposing ourselves into the situation of a narrative

Gadamer maintains that we understand by *transposing ourselves into the situation* of the story (Gadamer, 1975:305-6). He thus offers a view of understanding in which the difference in standpoint is not a hindrance, but rather part of the dynamics of understanding itself. Gadamer speaks of reading texts, and his is an interesting approach since differences and disagreement is a problem connected to delusions.

The *creative* aspect of understanding is a question of *how* we deal with the differences rather than avoiding or overcoming them. The possibility of understanding others does not come from within our identity, but by challenging it. Charles Taylor recognises that the hermeneutical experience may lead to altered self-understanding. Taylor has foreign cultures and life worlds in mind and does not say anything directly about the psychotic patient. Although he recognises that differences in opinion represent a challenge, he still maintains that it also entails possibilities.

> The challenge is to be able to acknowledge the humanity of their way, while still being able to live ours. This may be difficult to achieve and it will almost certainly involve a change in our self-understanding (Taylor, 2002:296).

Differences in opinion and perceptions represent a special challenge to understanding delusions. Delusions are extraordinary in this respect because of an *inability or unwillingness* to take the challenge. Instead of transposing ourselves into the situation of the story, it seems difficult to assume the premises of delusions and there might be good reasons for *not* assuming the premises of the other. It was in fact often difficult to relate to some of the stories of patients. This was a concern that not necessarily astonished the newcomer any more than the experienced staff member. Staff members could often present rather simple stories that were told by a patient, without knowing exactly what to do about the dilemmas that the story placed before them.

It was usually possible to use the stories as they were told. The story accounted for itself, and an attempt was made to explain the detailed information within the patient's terminology. The explanation was often an option even in situations and descriptions that seemed absurd. The stories usually made sense as long as they were re-told within their own contexts. This *internal coherence* was sufficient for understanding; however, it did not necessarily imply that any essential truth was discovered. How do we relate to these stories, especially the fictive stories? Is it possible to relate to a fantasy on its own terms?

Gadamer gives 'play' a central place in *Truth and Method* (Gadamer, 1975). He recognises that we may talk about play in different manners. Acting and children's play is therefore introduced as examples of play. Play contains its own context of understanding which not only constitutes a meaningful presentation, but also a truthful one. Truth is explained in terms of hermeneutical activity. Although the point of departure is literature and art, Gadamer describes text reading as a way people relate understandingly to each other (Gadamer, 1975:303). 'Hermeneutical truth' depends on the interpretative act in which meaning is acknowledged. The conditions established by the play enable us to partake in the recognition and creation of truth (cf, DiTommaso, 1996).

Is it possible to view delusions in terms of play? In that case, delusions not only establish information, but also create the context in which they make sense in way that is similar to the manner in which play constitutes its own meaningful contest. Play comes to expression only through the players. This is however only possible if the players *loose themselves* in the play by being *taken up* in its setting. The playing does not allow the player to behave toward play as an object. The player knows very well what play is, and that what he is doing is "only a game" (Gadamer, 1975:102). The activity or the playing itself constitutes meaning. The play is thus manifested on its own terms, which means that it creates its own context in which it must be understood. The special character of play allows for the constituting meaning without the need for further explanation.

The player needs to interact with something else. This does not necessary imply another *player*; however, the player will need something that responds to his moves with a countermove. Gadamer exemplifies this with the way a kitten plays with a ball, or how a football player reacts according to the moves of opponents, fellow players, and the ball. Playing is constituted by it's own activity. The moves are internal, which means that they relate only to the game itself. The game is limited to presenting itself, but may be evolved further by the players. Gadamer refers to children playing with a ball. The game is absorbing the playing child simply because it is fun, which in turn illustrates the aspect of self-presentation: The activity of playing does not need any further explanation. The activity accounts for itself.

Gadamer thus offers an interesting aspect of how a *context can be established* in which words would be received as meaningful. In order to use narratives as a framework and point of departure for describing another human being, they need to be placed in a context that will justify their use: One must accept the premises of the story. This does not mean that one has to agree in order to understand, but it does imply the ability to see things from the viewpoint of the other. By witnessing what others tell about themselves, we relate to what is said and done. In this way, the story does not evolve in an empty space, but within the context of a human relationship.

One could argue that a concept like this could legitimate taking delusions as they are. However, the situation of *reading a literary work* is different from that of *listening to a life history*. Nevertheless, the story may account for itself while also relating to others. Gadamer illuminates the aspect of interaction that is necessary for play. The narrative touches the other by offering a different perspective. The narrative may thus challenge our self-identity and perception of the other. The main issue about the hermeneutic experience is how the narrative changes our own perception of ourselves and of the other (Wirkungsgeschichte).

Establishing a 'self-contained' meaningful context implies instead the possibility to uphold the separation between fantasy and life. Gadamer thus places us in a dilemma. Hermeneutics offers an ontological explanation as to how we may relate to fictitious stories on their own terms. This means that we can keep life and narrative apart. Although the explanation does not exclude the possibility that even the fictitious narrative may lead back to life, such an effort is not necessary. Instead of opening the possibility to view life in terms of the narratives, we have the opportunity to do the opposite.

2.2. Delusions and fantasy

Fantasy is sometimes discussed in connection with delusions; however, this is usually done within a traditional concept of delusions and as a description of the inability to distinguish between fantasy and reality. In recent publications, fantasy is often treated as implicit in, or as the consequences of, delusions rather than as an explanation. There are nevertheless not many articles on fantasy among medical publications (MedLine). Those that are found are in relation to particular fantasies (like different types of sexual fantasies) and daydreams. Psychology (PsycInfo) has twice the number of publications and discusses several aspects of fantasy. In addition to concrete fantasies, a variety of articles debate different kinds of fantasies, as well as how they interact with self-image, reality, and mental problems. Philosophers (Philosophers Index) seem to take interest in certain concrete fantasies and often discuss those with regards to ethics. Despite some exceptions that emphasise a creative function of fantasies, fantasy is overall negatively evaluated as dissociation, flight from reality, or as being unreal.

It is necessary to treat fantasy as a genuine human experience without disregarding the possibility that a person actually may 'loose oneself in fantasy'. It is however not correct to contrast fantasy to reality. Fantasy offers a unique, and different relation to the world compared with perception or memory. The main problem is that it opens aspects that cannot be dealt with empirically. It is therefore interesting to look into the contribution fantasy may offer to the discussion of delusions.

There has been a certain development of the ideas regarding delusions and fantasy. Laing maintains that fantasy should be seen as a *genuine experience* of equal status with perception and memory. He furthermore sees fantasy as part of social interaction, but also as expansion and addition to, for instance, physical perceptible experience. The nature of fantasy is therefore different from memory and perception, and for that reason it is necessary to maintain fantasy on its own terms.

Fantasy makes an exclusive contribution to how humans experience the world; on the other hand, Laing describes how loosing oneself in the fantasy belongs to a description of illness and psychosis. He thus maintains that fantasy has explanatory value with regard to delusions. Since fantasy represents experience and a relation to the real, he thinks that psychosis arises out of a natural relation to the world. The pathological aspects are explained as "de-realisation-realisation", "sense of unreality", or loosing oneself in the fantasy. As fantasy, delusion can be seen as forms of interpersonal action (Laing, 1969).

What would it imply to take seriously a person who is 'lost in fantasy'? Do we find any circumstances that offer this as a possible approach? In principal, the question is not whether it is necessary to imply that we accept a narrative as true, either partially or in its entirety, but rather a matter of how to take into account what the person is actually saying.

Consider the case of a person, who according to a staff member, denied his family background. What is it that makes a person insist on this? One staff member described how she found it almost cruel to constantly remind the patient of the biographical facts. It was not only understandable why the patient didn't want to be confronted with what was real; however and more importantly, the staff member wondered whether this was always necessary or what purpose it should serve.

One could deal with such fictions as a strategy to avoid reality, or as dreaming. However, by viewing it as a manifestation of a psychological fact instead of biographical facts, we only indirectly relate to the fiction. The concept 'psychological fact' appears in some secondary literature on Freud's authorship as an explanation for his method of interpretation (Grünbaum, 1984; Ricoeur & Thompson, 1981). A fantasy is a psychological fact in this regard. Although a certain idea has nothing to do with the real world (knowingly or unknowingly), it is still a fact that the fantasy exists as an idea.

For instance, in the case history of the Wolf man an early memory plays a central role in Freud's analysis. The problem is that Freud cannot confirm this memory in any manner. He thus spends much effort in supporting the probability of this memory. However, he eventually depends upon the fact that regardless of what actually happened, it is certain that the memory exists as an idea that the client has (Freud, 1979). The psychological facts exist in their own right, although their relation to the real is significant. He does not want to completely disconnect the fantasy life from reality.

Freud also applies this way of thinking to delusions. Paul D Schreber was the only schizophrenic patient Freud ever analysed. Freud never met Schreber, who had written a comprehensive autobiography in which he describes, in a coherent and detailed manner, his perception of the world and his surroundings (Schreber, 2000).[7] This book was discussed in the period from its publication at the beginning of the twentieth century. Freud published a case study in order to demonstrate that the methods of psychoanalysis were also capable of dealing with psychosis. His procedure is to identify what he regards as key ideas in Schreber's book. These are reconstructed in meaningful frameworks that may explain the symptoms that Schreber describes. The ideas are thus explained in relation to each other.

There are several problems in Freud's analysis of Schreber (cf, Sass, 1994). In this context, it is important to ask how he deals with the unusual ideas in the material from Schreber. By treating fantasy as another type of entity, it neutralises the creative aspects of it as fiction. It is a double approach that allows us to study both the biographic facts and the stories of a patient separately, and to a certain degree to compare the two. The 'psychological fact' that could have offered a constructive and promising approach towards fantasies will instead transform the fiction into something 'harmless' and secondary. Although we might say that this method allows us to deal with delusions on their own terms, the problem is that it becomes too disconnected. It does not account for potentiality in that the fantasy evolves as part of a dialogue, like that of a patient and the therapist.

2.3. A tension between narrative and biographic facts

It is necessary to have an understanding of fantasies that accounts for how a fantasy may participate in constituting the situation as such, and not function just as another escape or

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[7] Schreber (1842-1911), a distinguished German jurist, began in 1884 a series of mental collapses that afflicted him the rest of his life. Schreber began *Memoirs of my Nervous Illness* in February 1900 while confined in an asylum, as part of an appeal for release; it was published as *Denkwurdigkeiten eines Nervenkranken* in 1903. The translation was first published by W. Dawson, London in 1955.

rewriting what is real. Paranoiac ideas may offer one example that organises fantasies into a tangible form. You may say to the 'paranoiac' that 'nobody is after you', yet it is still hard to deny that this perception may determine the meaning of everything that he sees.

Another question is whether the biographical facts did justice to the perception of the patients. One informant introduced herself as empress. How can one connect this self-description to *who* she was and how she saw the *facts* of her life? The point is perhaps seeing it the other way around, because her true biographical facts would not do justice to her own sense of being special and to her sense of dignity as a human being. Descriptions like the diagnosis and prognosis of schizophrenia were perhaps closer to the biographical facts because they underline and explain a life marked by crisis and hospitalisation. However, from her point of view, these facts must have concealed her ambitions and moral self-image, her worldview and view of life in general. Neither do the biographical facts do her justice as a unique, irreplaceable human being. Consequently, in order to express herself, she needed concepts that transcended the facts.

Such narratives are not true in a historical or biographical sense. The situation is also different from literature, where we feel certain that the author knows where the fiction starts and where reality ends. On the other hand, the patient narratives create a context of their own within which they make sense, and although they are obvious for everyone to see it is not certain how we should relate to such narratives. The patients certainly wanted to be taken seriously; and yet the context in which their stories made sense represented a challenge to the listeners.

The concept of fantasy does not account for the entire complexity and dialectic of understanding delusions. Fantasies will be seen as straightforward only as long as they are kept apart from that which is real. However, by accepting fantasy as a genuine experience, it is also part of what is real. What is not accounted for is when fantasy interacts with facts and thus becomes part of how we perceive what is real. We need a concept that might mediate or illuminate the connection between life and fantasy. This leads to a question of an evaluation of fantasy as a creative factor.

2.4. Fiction as dealing with something real

Ricoeur argues that through narrative we can bring heterogeneous elements together in one story. His first point is thus that the story transforms the *many* incidents into *one* story.

> In this respect, an event is more than an occurrence, I mean more than something that just happens; it is what contributes to the progress of the narrative as well as to its beginning and to its end. (Ricoeur, 1991b:21)

The 'inner' dynamics of a plot is the second point Ricoeur identifies regarding stories. The story involves "those who perform actions and those who suffer them"; it is the unintended circumstances, discoveries, and interaction ranging from conflict to collaboration. He exemplifies this by 'following a story', which represents a compound process "... guided by our expectations concerning the outcome of the story, expectations that we readjust as the story moves along, until it coincides with the conclusion" (Ricoeur, 1991b:21-22).

The third and final point is the twofold timeline in a narrative. From a certain perspective, composing a narrative entails the possibility of drawing a configuration out of a succession of events as they are placed in relation to each other. The narrative composition has therefore a temporal outline which is not only important, but that also offers interesting possibilities. Ricoeur establishes that time is not only what passes and flows away, but also what endures and remains. We must see the temporal identity of a story as something that mediates between that which endures and remains, and that which passes and flows away. All three aspects draw attention towards the narrative as unified and complete. The *point or intention* of the story is that of intelligibility. The narrative intents to communicate something to us; there is something to learn, something will be revealed and learned from the story.

Anniken Greve argues that *fictional* stories may also represent a *truthful* picture of the actual world (Greve, 1999:145). She discusses circumstances in which sticking to the facts may actually entail the possibility to conceal or even distort definite and real characteristics of a person. This is especially noticeable when accounting for dreams, goals, and intentions. Greve maintains that narratives play an essential role in defining facts. Imagine how a seemingly empty act, like stirring a cup of tea, manifests different aspects of meaning in light of different stories. It is, in any case, something more than 'moving the water around'. It might, for instance, belong to an irritating context: "... the stepfather that cannot stand the sound of the spoon against porcelain". The description then reveals the perception of the act, its intention, or the role that the act plays in its context. This actually happens, although it is something different from the act of dissolving sugar in hot water.

Greve's essay exemplifies this by aiming at taking the role of the fictitious story to its limits. She does that by interpreting a *fictional memoir* by Tobias Wolff (1992). In *This Boy's life: A Memoir,* we meet a boy with petty criminal behaviour. These circumstances do not, of course, generate particular enthusiasm, and the stories about him are thus nothing of which to boast. At this particular time, these stories have become essential to him. He has ambitions to be admitted to a better school in order to escape a violent stepfather and start a better life. To achieve his goal, he steals papers and envelopes with the letterhead of the school. He is then in the position where he can fabricate everything he needs of recommendations and grades. On the one hand, Greve admits that everything he writes is seemingly a palpable lie. On the other hand, the mere biographical facts simply do not account for his *true ambitions* and will even serve to conceal them. The deliberately untruthful self-presentation is therefore necessary for him in order to be evaluated in terms of his *true* ambitions, his will to change, and his true self-understanding. He seeks to avoid being evaluated only in terms of the life from which he tries to distance himself. Fiction represents, in this context, a different approach to the real as compared to empirical descriptions as a manner of presentation; hence, it represents another form of knowledge about the real.

The intention of Greve is to underline the *truth* in *imaginative literature*. She investigates how fiction not only can be part of clarifying or accounting for historical events, but also how literature may reveal essential aspects of human nature. The advantage in fiction is that it approaches the material in a free manner and consequently communicates its content differently. Instead of describing unquestionable facts, Greve suggests that we consider fiction as a good description because we recognize our own ideas, emotions, and perceptions in the narrative. At the same time, fiction clearly adds an aspect to the description of the world that cannot be accounted for by mere descriptions of facts. The justification of the fictive story is that this addition is essential and cannot be paraphrased into other propositions.

The advantage of Greve's example is to show how the meaning of a story is not only self-contained and internal, but that in addition it offers a genuine and truthful description of the real. Her example also illuminates some of the problems with these descriptions. Since self-narratives will always be related to biographical facts, they will entail a tacit claim that what we tell must also be the case. On the other hand, in the example the narratives that were created not only offered an additional aspect, but also directly contradicted known biographical facts. When we relate to the fictitious story as fiction, it does not just represent the internal meaning of a narrative. The problem is rather the implied transition from narrative to life.

According to Ricoeur, this leads us to assume an unbridgeable gap that separates fiction and life: stories are recounted and life is lived. Ricoeur argues that we, for a moment, assume the side of the narrative and hence that of fiction, and then see in what way the narrative leads us back to life. This is no unambiguous way, nor is it given that there actually *is* a way back to life. Ricoeur argues that the process of composition is not completed in the text, but in the reader. The sense and significance of a narrative occur only in the intersection of the world of the text and the world of the reader. "The act of reading thus becomes the critical moment of the entire analysis" (Ricoeur, 1991b:26). It is in this intersection that reconfiguration of life by narrative is possible.

This is important to Ricoeur because he takes it further by pointing out the aspect of self-understanding in fiction and particularly narrative fiction. He insists that as long as we may maintain that fiction is only completed in life, and that life can be understood only through the stories that we tell about it, then an *examined* life is a life *recounted.* Ricoeur places himself close to Heidegger when it comes to understanding 'identity', but adds an essential *narrative* aspect to identity. Identity is thus not only 'the story about ourselves', but being a story, it evolves as a composition of heterogeneous events developed in interaction with others.

Despite what may be described as a 'looser' relation between fiction and reality, its basis in the real depends on the creative interaction that stands out as a problem when relating to delusions. Ricoeur implies the possibility of relating to delusions as self-descriptions. It is therefore of interest to look into the deluded narratives in order to see *how they lead back to life*. We then assume the position of the delusion at least for a moment. However, we do not assume that there actually is a way that leads back to life or that the way is unambiguous.

Not every aspect of what is going on in a conversation can be made explicit; moreover, it is hardly controversial to say that psychosis may represent an additional challenge in conversation. However, this does not necessarily mean that psychosis presents us with different premises for understanding as compared to other verbal communication. The question is how we make the transition from life to narratives and how we may relate the narratives back to life. I want to illustrate this by showing how a particular situation, in which I was a part, is transformed into a text. That which is special about it is the manner in which the patient tries to find the right words that will explain his situation. From my point of view, it is special to follow how he is thinking aloud, playing on his words, and trying to take into account every expression of the interaction.

A single conversation may refer to a lifetime. Some of the topics in the following dialogue refer to incidents that date 40-50 years back in time, while others are recent and current activities at the unit, and yet, they are presented side by side in a dialogue. The timeline of the conversation is therefore different from the timeline of the patient's life. He sees continuity in his life and tries to find possible explanations for his problems.

The following paragraphs present transcripts from a single conversation and an evaluation of the process of writing it down and translating it.[8] The intention is to investigate my own experiences from talking with patients, as well as how the conversation is transformed when

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[8] Some passages have been omitted in the transcript presented in order to shorten it and others from ethical considerations. The Norwegian version includes the actual words that were recorded on tape. Dr Gerald Mustard, for whom English is his first language and Norwegian a second language, has assisted me in validating the English translation with regard to the original text. We are certain that the translation is as close to the original as possible. Some re-writing is always necessary when translating in order to maintain the meaning in what is said (Idiomatic translation). It was also essential, as far as possible, to maintain rhythm in the text, choice of words, interruptions, repetitions, disrupted speech, etc. Some words may feel untimely or erroneous, however, this has been done deliberately when the Norwegian text would appear like this to a Norwegian reader. It was an option to present the two texts in concordance, however, this would not solve the problems of translation and would not be helpful at all to the English-speaking readers for whom the translation is meant for in the first place.

being changed into a text. I will ask whether the most significant transformation actually happened when transcribing the text and not when translating it.

The keyword is the *interaction* that is constituted when speaking with the other. In order to maintain the dialectic of both *illness* and *possible understanding,* the important question is not whether *we understand,* but rather *how we understand.* It is important to disregard neither understanding nor the problems involved.

3.1. A single conversation

Patient: But I have such ... I have anxiety. The Anxiety is … no … it is very peculiar in a way. If you get rid of it, then the anxiety changes its pattern all the time; do you know what I mean?

I: Well, not exactly…

P: No, If I (clearing his throat) if this … if it has been anxiety against flying, then I do not fly, then I fly, then you again will have a panic attack for something else. That is what I think is so peculiar about the anxiety.

I: So if you….

P: … get healed in one way, then it returns anew in some other way.

I: It reappears?

P: Yes! That is what happens. (Pause)

I: So, you have a hard time right now, don't you?

P: Yes, frankly, yes. I have had a hard time for quite a while now, but (clearing his throat) but maybe it has become a little more like this lately. I also notice the difference now that I am only allowed to have three holes [of tablets] a week. I really want more, but I have to save these three holes and that makes me be fired up even more. I was out, not last Sunday, but the Sunday before that, but I managed to drink about six pints of beer. (Pause)

I: So you think that if you drink alcohol, you think that the anxiety is easier to….

P: Yes, you become more on top of things, in a way, and then you become like, yes, you don't think, and you becomes almost like a world champion. You might call it that, to use a kind of big word for it. You get on top of things, in a way, and yes, then your muscles relax, and, … such and,

I: You talked about flying, have you been especially afraid of flying lately? Have you been out flying?

P: No, not in the last eight years, but I have not, but if one could manage to do it, one could have travelled to Svalbard. However, that there, eeeh, this here is anxiety. Some times you must have very strong nerve medicine, and not just one tablet, but maybe three or four before it helps. There has been a lot of fuss about going on these long walks and where one should go. I have been on six trips this summer, but then the first trip was nine hours away, then one could manage, and the next was six hours. You become gradually more tired for each time. Then it is food…all the fuss about cooking, too. It will be taken up again and many good ideas for what one might learn and become better at cooking and making dinner and such, too. They want us to go down to the hospital kitchen where they want to teach us. I don't need that, but they can't understand that. They fuss and some … pull on those threads in one direction, and others pull in the other direction.

I: So it becomes too much to deal with? Do you get tired?

P: Yes, I get tired.

I: You mostly cook for yourself, or…

P: Well, it is, you know, kind of easy stuff, but that is more than enough. It is just as important with spiritual nourishment.

I: That is kind of two different things?

P: Yes!

I: How do you get spiritual nutrition, then?

P: No… you try to get in touch with higher powers, sometimes. Must get the Bible. I have read very little, only from time to time. I look over the newspaper and such, but I have not read anything even though I have an exciting book and so on, but I struggle with such a lack of concentration. I lack concentration and I'm not in a positive mood, but I have been like that from childhood. But it is now…but it is clear that it would have helped to be more active and such, but I have experienced that I will never be that way. I'm not really any more healthy.

I: Do you experience that it always has been like this?

P: Yes, more or less. Of course I … I did a little such there … one experience such flight of thoughts, but … experienced flight of thoughts, but I … but I … for instance, but when you for instance go to sleep, then one thinks, then the thoughts return anyway, like when one is in a lot of activity and might be at the sports centre. Used to be there once a week, some times twice. Then I experienced that I thought… yes, we played football, that I thought of the next thing to do, that was to fetch the dinner. I kept on like this … I did a lot of that for three months, but didn't get any better.

I: But when you say that … flight of thoughts, what do you mean by that?

P: No…, it is the difficult life you have, and my mother that visited yesterday and had … has a very hard time, too…

I: Trying to think of something else, is that it….

P: No, but it is connected to the mind. I have a very weak mind (drinks a large glass of water). That one manages to build up one's psyche, and that one in a way becomes like such a lamb of God, that one in a way puts too much on one's own shoulders, that one shouldn't have and such, well, …. Yeah, sometimes I feel that I … well, have anxiety about coming into the hospital, for I feel that it is much that, in a way … evil things in the walls…. To tell you like it was, there has been a lot of life, but it was after one that moved to A. Then I began the turmoil. Pretty ill she was, and she did actually believe in the creator and … then when I started the fuss down there, both among the patients, some of the patients and the staff and, … well, I think you know what they… what we talked about them that was on the staff at B. …. They have to take such. What he called for them in a way where… yes that I got psychosis, or that I became psychotic …. They knew yes, of course that it was just to take medications against precisely that. It was not … I do not know whether you understand what I mean?

I: …no, I am a little uncertain. It was kind of … it was in connection with the time you came to the hospital, is that correct?

P: No, it was somewhat later.

I: Ok! But they meant that it was the psychosis that caused it?

P: Yes.

I: What did you experience, is it possible to tell?

P: No, it was peculiar things. When I thought of stuff … different stuff … they looked at me, and they smiled cunningly (short pause) …

I: Who smiled cunningly?

P: No, it was one, a woman … even after … then she went away, and then another man and it continued then, too. A lot of strange things happened. I got a huge nervous attack in my room; the time was a quarter past eleven. In exactly the same moment, she came out of the room. A lot of things like that. I do not want to go into it any further…. unless you have any questions or something. (Fills up the glass with water)

I: No, I see … when you put it like that, then I see it must have been difficult for you, that it was very hard...

P: I loaned money to a guy, loaned you know to a guy up here, for tobacco, should have been paid back by Monday, but I have not received anything. There are several who have borrowed money for tobacco, but I have one, I do owe some money that I try to pay back a little at a time, so that … I am quick to give stuff away, you know, it is not easy to be exploited … get exploited like that (Pause)

I: So you think that it is important to be a jour with what you have borrowed and not borrowed?

P: Yes, quite. Then it is so bitter to be cheated on. One shouldn't cheat others. Still, it was a time when she had …. Twice she had quite a lot of cash, then I have been drinking in the city, but I have paid her back, exactly that. Yes, it is 70 crowns (Approx. £5) that lacks from that occasion, and five, six hundred crowns (£35-£40) a couple of times. No, I get so sick from the alcohol and such, but if one just had been able to stay awake, and eaten and drank much and not gone to bed while getting more and more drunk, then … No, I am a sinner.

I: …you mean that?

P: Yes, don't you think that?

I: We have spoken about that before.

P: What do you think of tax collectors and such?

I: Tax collectors??

P: Yes, they did as they wanted, and …

I: they took …

P: … many will have more and the devil will have all (Norwegian expression)[9] (Pause) I feel kind of guilty about my mother, but I was also immature for the age. That I have…I can thank them at home for, both my mother and my father, especially my father and …I think it is sad to see how hard my mother has it. It actually touches her that she has a son that is mentally ill, so… The one brother of mine, (he loosens up)…both the other brothers of mine, one of them I have not seen for over two years and such an ….but, I pity my mother, with sons like that, but I also have been such, Yes have been, …. behaved badly many years back, especially many years back. When I was…was committed to [Name of the Hospital] I drank sometimes, and so I went home to her and behaved badly sometimes and then also… so she had to move…yes, the sooner the better … yes… I have been such… I kindly despair over…such things also… that it is such.

I: Do you feel that she bears a grudge against you, or….

P: No, it … No, I do not know that … no, I do not think so. It had been easier to claim, when it belongs to the Lord.

I: But against your father, you do not have…

P: …any choice? Contact with?

I: Yes.

P: No, not that … not lately, since he has no phone where he lives. If he had a phone, I would have called him occasionally. (Pause) No, I do not know. I have felt kind of a little like that … maybe a little desperate … kind of and that it should be like that … yes, kind of that you never had any life, in a way … yes, that it was .. that you never had that kind of life … you are only a product of … you have grown kind of crooked … it is also confusing that … yes, that being together in a well-

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[9] "Mye vil ha mer og faen vil ha flere"

ordered fashion and … and should be like that .. yes, kind of that I do not have that … birthday when you were a kid and then he had perhaps been drinking and kind of .. he slept, and so then had hangover. There was never any soda, perhaps, just juice and such for birthdays and … then it was many things that happened like that. Once he fell down and got hurt, right by the place we lived, he made a shortcut, then he bled half a sink full of blood.

I: Oh, then …

P: … then … I saw that, I saw it and … it was a usual servant … washstand and … yes and … almost two litres, one and a half, almost two litres, then there was the times when the police came and fetched him, when he started to make too much fuss, a couple of times, that I remember. I remember once … another time, too .. he refused to go with them before he had eaten three or four slices of bread. Then I was arrested for some pilfering. The mother and that country policeman and … something about some keys and … was supposed to be taken to the police office and … I threw the keys out of the window, or something, I was placed in that ship's jail, the jail there, at [name of place]. When I was 13 ½ years old, twice locked up, I have so much anxiety about being alone, have been so damn much alone and stuff, but I … it is really just one that … that I can talk to .. since the other is kind of so much away …

I: In what way?

P: No, she is not down to earth in a way, she is freaked out … wicked … don't know whether she has used LSD or something like that (pause) No, I heard that it was … no, do you know that it has to do with schizophrenia, that I perhaps am sitting and talking about something, then I think … then I think of something entirely different.

P: (…) Do you know [Name]?

I: Yes, I have met him, I think. (which I in fact have not, misunderstanding)

P: He is a tall, big guy. He was a neighbour. He and my father were out and searched for me, when I was about 13 years old.

I: Did you run away from home or anything like that?

P: Oh .. I had moved from .. it was not endurable .. to live like that … to be like that. So .. I was immature for the age, as well, I did not know my own good. Was exploited to pilfer and … When I was 13 years old. That is why I … do not know what stage I was … that I was on the level of a kid 10-11 years of age, perhaps. Then I was stabbed in my back by … one like that … yes, they blamed me in a way, when they were caught, and they told them what had happened … then … but the one that did it, he died a while ago … 1 ½ months ago. It was kind of sad in a … in many ways. He never even hurt a fly or anything, although he might have been a plague for the businesses and those down town. And such. And the watchmen there…. But it was unfortunate in a way. But then I thought that it … they that might be excused, for instance those who have lived a life in the bush. An entire life, they do not know anything outside, cannibalism, they are excused, because they have never heard it, the ten commandments for instance. Then there are those who … yes, those who don't have … get the faith of one's childhood. Are they 100% excused in a way, if they do something, or is it … if they … or is it something … what do you think of that?

I: So … you are thinking about something like ..

P: … I have of course …

I: … people that know, or should have known … are more responsible for what they do?

P: No, if they do not have the faith of their childhood, don't they?

I: Well

P: Well, then they do things. Break the ten commandments, you shall not desire, commit adultery and filch and such. Will they be 100% forgiven, since they do not have already the faith of their childhood … is it a responsibility one has, or?

I: (uncertain) Do you not think that people should take responsibility for what they do, notwithstanding?

P: Yes, not all, but a lot of them. I do a lot of things that I do not want to. And I also did....

I: Yes, but .. and ... it seems like you in many ways are very hard on yourself. Do you regret any of what you have done...

P: At least I am fair. For sure, I have made some mistakes, but at least I have ... I want to say that I have learned from it. Then you have some folks, former friends, (...) they keep up their appearance in a way, they are taken advantage of sexually, and such. So they hold masks over themselves in a way, and they are more accepted in a way. And that is on false premises and principles, and lost so ... yes ... it is then it is him that they talk about after he died, about leave and stuff .. I need and asked if I ... for he has helped me some times and I helped him ... he the chief psychiatrist, whether I wanted to talk to ... whether I wanted to talk to students and such ... and that I did, and .. even though ... they was upset that it was possible to live like this – to have so hard a time, in a way. Even though, yes, even though it was not so ... yes, it seemed like, that it was not like this, not like this. It was only half of the hard facts, in a way.

I: .. that you gave them ...

P: Yes. What do you think? Do you think that I am too hard on my self?

I: Well, like ... yeah, hard, no ... no. Hard is probably not the right expression. So ... but you are very concerned about what you have done and that you feel is wrong.

P: ... that people have done something wrong?

I: Hum...

P: What did you say?

I: Of those things that you have left behind ... really. You mention pilfering, you mention things that you have been tricked into, and so on.

P: Yes. (Pause)

P: Who was it ... many times I am about to speak and not ... that I call a kind of leprosy, in a way ... modern such.

(The conversation comes to an sudden end. After we listen to the radio, he makes some comments, then he excuses himself for being tired. Then we exchange words of farewell)

3.2. Association and dynamics of the conversation

If one decides to read the dialogue first without paying attention to the observations and conclusions, it is interesting to notice how the patient starts speaking about something, and then either forgets that or gets some other association, and continues to still another subject. The temporal, spatial, and cause-consequence connections in the conversation become chaotic. He expresses something, but is freer with regard to the 'usual' constituents that we use when we speak. When he does not do that, the conversation takes on an unusual and, for us, broken manner.

It is interesting to follow his associations in the dialogue. A good example of this is the passage when he tries to communicate some elusive memories:

P: No, it was one, a woman … even after … then she went away, and then another man and it continued then, too. A lot of strange things happened. I got a huge nervous attack in my room; the time was a quarter past eleven. In exactly the same moment, she came out of the room. A lot of things like that. I do not want to go into it any further…. unless you have any questions or something. (Fills up the glass with water)

I: No, I see … when you put it like that, then I see it must have been difficult for you, that it was very hard…

P: I loaned money to a guy, loaned you know to a guy up here, for tobacco, should have been paid back by Monday, but I have not received anything. There are several who have borrowed money for tobacco, but I have one, I do owe some money that I try to pay back a little at a time, so that … I am quick to give stuff away, you know, it is not easy to be exploited … get exploited like that (Pause)

It appears that when I ask him about something, he seems to 'catch' one of the words, gets some associations with what he worries about, and then starts speaking about that so that there is a frequent change of topics. He might, for example, have heard the words ‘difficult’ and ‘hard', and these could have reminded him of his experience with other patients when relationships were hard for him, and as a result he changed the topic towards borrowing and exploitation, which he might have connected to these persons. The response came immediately; it may also be noticed how he interrupts me in the middle of what I am about to say.

My role in the conversation is to reflect what he says and try to follow his associations. I often try to make him elaborate on the details, but perhaps the most important feedback I give him is when I do not understand him. The conversation then becomes freer for him. It is easier to associate, or ‘think aloud’. These features may be partially a result of the context as well as the effect of illness, tiredness, and drugs. It would therefore be interesting to try to be even freer in the interview, and thus to encourage him (or another person that is not a patient) to speak and express himself as he might wish, without trying to lead him back to the topic. This would mean trying to let him continue a monologue without having to dialogue with me. Thus, I would merely be a silent listener. What will come from that? Where will his thought 'fly'?

The other aspect is that he is actually in a conversation in which he tries to make me see what he is thinking; he is explaining and telling me what he means. The alternative focus would be on the dialogue that occurs. I might give him the time he needs to explain, and just allow him to follow his own associations without being conscious there and then that he has these associations. This would be to focus on the role of the interlocutor. In prolongation of this, it would have been interesting to try to encourage the patient to express himself in another way, or try to interview other persons in the same manner. The topic of the conversations is actually of secondary interest. It could be something they enjoy, like drawing, music, building something, or whatever they want to speak of. Alternatively, are there other means of communications, like art or music, which could more perfectly express their way of thinking and would give us the possibility to see or hear their artistic expressions? How would such expressions be treated?[10]

One impression from the text of the conversation is that the patient is egocentric or even solipsistic. When he speaks, the text does not indicate that he *thinks* about me as an interlocutor, although he asks me about something and he even replies. Nevertheless, it seems that he does not worry whether I will understand him or not; at the same time, he wishes to be understood. There are no clear passages in this text. He moves from topic to topic as a continuous 'stream of consciousness'. It is like one continuous long sentence, and the text of the dialogue illustrates the way of thinking, the progression, and dynamics of a conversation. The problem with dealing with such a text is that it is both definite and loose at the same time. It is limited to this particular setting, restricts itself merely to what was actually said, and yet, the question of what it means is relatively open. Moreover, there are the questions about the origin of this kind of text, such as how its construction and retelling will influence its meaning. I will start by looking at the process of recording and writing down an oral conversation and transferring into text.

3.3. The missing context

The way the text is understood depends not only on the circumstances in which it was produced, but also on the context in which it is read. The reader therefore adds a fundamental *uncontrollable* aspect by introducing her own context which might be totally disconnected from the conversation, the people involved, and the process of writing.

The intention of writing is to transcend the singular context of the localization. This adds limitations to any text, but it also offers advantages. Since the text isn't limited to the initial context, it adds a creative aspect that transcends both the authors' intentions and the situation it describes. In a certain sense, the text does not account for anything but itself. It will have a 'life' of its own, apart from its author, simply by being published. This is still true even if it was written as a faithful recapitulation of 'what was said'. Understanding 'what was said' will always be an act of interpretation. Moreover, *reading* the text will imply yet another encounter, this time

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[10] Some material exists as a consequence of this fieldwork, but it is not enough to say something general about these structures. The comments will therefore be delimited to this actual conversation.

between text and a reader. This does not have to imply relativism, although it disregards the possibility of a direct relation between the text and that to which it refers, viz., in this case, the original conversation.

Reading a text is not without reference to the initial situation; and yet, the task of reading, which necessarily includes interpretation, will fill in the 'missing parts' resulting in a more complete perception of the context. It thus constitutes a context of its own in which the reader relates to the initial situation through the text. Consequently, the text is something other than the situation that it represents. Hence, the text makes the original situation accessible to others, paradoxically by disconnecting it from the situation in which it happened. Instead of perceiving the 'changed or missing context' solely as a problem, it also involves possibilities. Ricoeur explains this in terms of 'eclipse of the surrounding world' (Ricoeur, 1991a):

> When reading, we can remain in the suspense of the text, treating it as a worldless and authorless object; in this case, we explain the text in terms of its internal relations, its structure. On the other hand, we can lift the suspense and fulfil the text in speech, restoring it to living communication; in this case, we interpret the text. These two possibilities both belong to reading, and reading is the dialectic of these two attitudes. (Ricoeur, 1991a:113)

Since the text exists independently from a speaker, this will be an inevitable property of any text. The text *will* be understood differently because different readers have different interests, background, and viewpoints, and thus find some aspects more interesting and central than do other readers. We simply perceive *the same* in *different ways.* An uncommented reproduction of a single conversation might make this openness more conspicuous than any other version or genre because of all that *isn't said* in a verbatim. The text demands an explanation of what it means to say.

Some interpretations and remarks are made explicitly and are part of the transcription. However, the transcription as a subjective report goes mainly unnoticed and unaccounted for, despite the fact that some interpretations and choices that as a matter of necessity have been made, really makes a difference. The faithful recapitulation in the field journal has the advantage that it accounts for how it was perceived. For this reason, it appears as less accurate than a verbatim.

The goal of the recapitulation made in the field journal was to make a correct presentation as regards the content of what was said. The goal of the transcription, on the other hand, is as far as possible to give a literal word-for-word presentation. The advantage in the recapitulation of a field journal is that it is clear *who* tells the story (authorship).

3.4. A productive notion of explanation and understanding

Ricoeur criticises the opposition between the 'detachment' of scientific explanation (erklären) and the empathetic access to another subjectivity demanded by the human sciences (verstehen). The distinction is based on false assumptions about understanding, and Ricoeur wants to establish a more productive approach to explanation and understanding.

> This in turn leads to Ricoeur's most original contribution to this debate: The positing of a 'productive notion of distanciation' as that which permits 'communication in and through distance' and so constitutes the very historicity of human experience. Understanding and explanation, far from designating opposed fields of inquiry, presuppose and enriches each other (Clark, 1990:107)

Ricoeur identifies two different preoccupations within the tradition of hermeneutics. First, it is a movement of *deregionalisation.* It seeks to enlarge the area of hermeneutics by incorporating varieties of hermeneutics within a *general framework* (Ricoeur et al., 1981). Hermeneutics as a method may be thought to constitute an objectified layer of understanding that is directed towards inscriptions of culture in which life has come to articulation. Although hermeneutics as a general method invites to application within a general framework, it depends on the delimitation of the 'properly epistemological concern of hermeneutics', which allows a major revision of the problematic so that hermeneutics becomes 'not only *general* but *fundamental'* (Ricoeur et al., 1981:44). This fundamental hermeneutic turn becomes a second concern and the enterprise of 20th century hermeneutics. It disentangles itself from the effort to establish an epistemology of understanding and instead strives to describe its properly ontological conditions. The question of hermeneutics is detached from a description of a method for investigating how humans relate understandingly to each other and the world.

Clark argues that Ricoeur sees distancing as the condition of liberation of the text, not only from its conditions of production, but also from its material substratum. Clark criticises Ricoeur, on the other hand, for while seeking to "… preserve a scientific objectivity for depth analysis of the text, there is no detailed consideration of problems of verification and adjudication of the residue thereby revealed" (Clark, 1990:109). Acceptance that theories and texts construct their own criteria of relevance implies a double problem. First, as long as hermeneutics is seen as a fundamental condition the shortcomings and problems of understanding cannot be ascribed the method. Second and consequently, it endangers the concept of knowledge by disconnecting it from its reference to perceiving it as an internal dynamics.

Ricoeur does not offer a way out of this situation. Hermeneutics is rather a question of utilising the conditions, which in itself offers a productive and creative notion of knowledge. The question is how the concept of distancing may contribute to the qualitative researcher who is not only involved in producing texts, but who is also involved in interpreting and describing them. The detachment of the text not only from the conditions of production but also from its material substratum, means that even the originator of the material (through field work) and the text (transcribing/recapitulating) is placed at a distance from his or her own material.

Transcriptions are just one among many texts in the context of research material. The field journal was also an essential tool during the entire fieldwork. Even though these two tools employ different approaches towards the material, they also involve clear intersections. The conversation was, for instance, described and recapitulated in the field journal as well. The transcription of the conversation was made more than a year after it was recorded. I consulted the text in the field journal only *after finishing* the transcription. The field journal included a recapitulation written from memory within 24 hours after the conversation; however, I did not deem it necessary to change or add anything to this description after completing the transcription of that same event. The journal lacked some information regarding *how* things were said (the exact words); yet, it contained the essence of everything that was said, including the most important statements quoted and paraphrased using the original words. This I could confirm with the transcription.

In addition, the field journal included my own reflections, as well as information on the surroundings and the context. The clarifications and interpretations in the field journal *add* a decision as to *what it means.* The field journal had then moved one step further in the investigation, as compared to the verbatim, and yet without loosing anything significant in its representation.

However, is it feasible to imagine any access to the event apart from subjective reports? Transcriptions do not solve the problem of subjectivity, and since the context of the text has changed from the situation of the conversation, the meaning is likely to be misunderstood or taken differently if the reader is not guided by the author's interpretations and clarifications of the context of the conversation. These are however no major objections, they are rather clarifications of what we may reckon as 'documented' by texts produced by qualitative research.

Even if we have documented the actual words that were used, what they meant might still be in the open. Every word will create several possible associations or senses.[11] Every concept will in addition, simply because they are words, make possible different descriptions, explanations, or expressions. The meaning is not fixed. When we, on the other hand, perceive their meaning as more or less fixed, it is because of our preconception of the given context and habit of viewing certain utterances in specific ways.

These preconceptions will be part of a totality of understanding and thus are hard to account for in detail. What stands out of the text or conversation will be understood in light of the dynamics between the totality and singularity of both words and contexts. In order to make an exact reconstruction on 'what was said', we must also actually define every word that was used, which means that we must describe and define every aspect of the context.

The possibility of exactness is therefore neither feasible nor desirable even in a simple task like transcribing a tape recording. First, the only exact description would be unmanageably large, and second, the defining and describing of both content and context would move the project of exactness into an infinite endeavour. It would not only alter the context, it would also go beyond the mere report. The most accurate transcription can therefore be the least honest because, by suggesting that it is *accurate,* the importance of the *author* and the *context* in which the text is written is also reduced or overlooked. In addition, it misses the change in grammar from the oral to written language.

It is noticeable how quotations in articles based on qualitative methods refer to verbatims that consist of complete and coherent sentences. It is of course imaginable that my informant, due to symptoms of schizophrenia and drugs, is less articulate than others are. It is true that the speech was experienced as difficult to follow. However, I have several recordings of staff and patients, as well as of my self. In one of them, the head psychiatrist, whom I perceive as a person with extraordinary language skills and vocabulary, explains his work and views on drug

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[11] For instance, 'is' might be used as a copula, but it might also be synonymous to 'exist', 'being', 'equal', or 'presence'. Moreover, it opens up for even more subjective and context given associations. In this dialogue, 'to be' was associated with a great deal of anxiety. "I *am* often awake at night" which was said in connection to being awake and afraid at night. Important aspects of what is said may be hard to account for by simply referring to the exact words used without placing them within a context.

treatment. His speech stands out as eloquent and coherent. He explains the use of medications in a way that is unproblematic and easily understood.

A transcription of his speech was then produced in the same manner of thoroughness as the example above to see what this conversation would look like in written language as compared to the one with the patient. This text was also characterised by interruptions, incomplete sentences, leaping from subject to subject, etc. Although the text from the conversation with the patient seems more chaotic than the initial perception suggests, it is of course possible that the text represents the "truth" and that my impression was, in fact, insufficient and that the speech was incoherent. However, it is more plausible to assume that the spoken versus the written word makes sense based on different contexts and grammar and that one transforms the grammar of the conversation when it is replaced by the text. This means that the most 'accurate' transcription will involve certain rewriting to accommodate this change in grammar.

The text above reflects an actual conversation by copying every word; and yet, its content is inevitably changed simply because it is written down. This is especially clear in a faithful reproduction, word for word. This kind of accuracy works against readability and thus suggests inaccuracy. The question is therefore not how to overcome this transformation, but how to deal with this change and attend to it as a positive resource for qualitative research. On the other hand, if the hermeneutic circle cannot be avoided, then the crucial question becomes when to stop, and where to start or, in other words, how to utilise the hermeneutic situation into which the method places us. The problem with even the most faithful exactness (word-for-word) is that it says nothing about the basis that makes these words understood.

Any transcription undergoes some rewriting. This rewriting is done when the verbatim is written out in more or less complete sentences. It is rewritten simply by transforming the conversations into texts. Although tape recording and other technical remedies may help us assuring the quality of the final text, we will never avoid the questions of *who* is telling the story and *why*. The question as to whether the narrator *represents* a truthful picture of the research object will be rooted in a question of the credibility of that person as narrator.

PART IV:

UNDERSTANDING AT THE LIMITS OF LANGUAGE

1. INNER STATES AND THE PROBLEM OF PRIVATE LANGUAGE

Philosophical Investigations develops a line of reasoning that often is referred to as the private language argument (PI §§243 ff). The theme is rather peculiar because, according to Wittgenstein, there cannot exist anything like a private language. Nonetheless, the passage has become like a touchstone for everyone who wishes to work within the ideas of his later philosophy.

The debate has mainly divided into two groups. One side maintains that language is something that several speakers *actually* share, while the other side argues that language must be something that they *could* share. These views are recognized as the 'community view' and 'the solitary speaker view'. There is a spectrum of views within the range between these two extremes (Hertzberg, 2003b). Hertzberg adds that the discussion seems to have stranded there; at least, there are few new topics found in the publications on the private language arguments, as if nothing has happened since Rhees' claim that the private language arguments show us "how words mean" (Rhees, 1970:55).

By advocating either the *possibility* or *necessity* of shared language, both positions within the debate point towards a third modality viz. the *impossibility* of sharing a private language. The private language arguments thus demonstrate what language is not. A too limited perception, or a misconception, of what it means to understand may turn out to be problematic when we attempt to account for how we refer to inner states like sensation or perception.

There are good reasons to resume the debate in the context of psychiatry in order to meet the patients' request to be taken seriously. Experiences of schizophrenia are associated with difficulties of articulation, and Sass may be correct in his assumption that even the most articulate persons seem to loose a proficient vocabulary and fall back on hopelessly insufficient phrases and metaphors in relation to such experiences (Sass, 1994).

Understanding depends on a language capable of dealing with inner states, sensations, and feelings without depending on private definitions. How can we be certain that psychosis avoids the *impossibility* of being expressed in a *shared language*? The clue will be found by looking at the elements psychotic expressions have in common with expressions of inner states in general.

1.1. The placement of the private language arguments

Wittgenstein's reasons for including the arguments in *Philosophical Investigations* (§243ff) have been debated. It has even been suggested that the discussion of the monologue in §243 might have been included by a mistake (cf, Hertzberg, 2003b). There is no consensus as to what actually is at stake. Moreover, Wittgenstein does indeed deal much more thoroughly and conclusively with both privacy and the public character of language in other parts of *Philosophical Investigations.* The question thus remains: What is the purpose of the arguments if they are not set up to demonstrate that language must be shared?

A private language consists of words and complete expressions that are defined within a private sphere. Others will therefore not have any certain clues as to the references of the expressions. With no possibility to introduce others to such private definitions, the language lacks the ability to transcend or communicate beyond this private sphere. It is consequently only an apparent language because the expressions cannot convey any meaning.

The argument is a rather 'backward' approach to substantiate that language is shared. Nevertheless, the arguments should not be taken as rhetorical. By proposing the possibility of a private language, Wittgenstein risks his entire project that depends on the public character of language. Hence, the denial of a private language must be definite.

First, he argues that speaking of inner states does not depend on a private language (§244).

Second, inventing a private language with private ostensive definitions cannot be understood by anyone, not even the speaker himself (§258).

Finally, even if there where such a thing as a private language or private ostensive definitions, it would not play any role in language. It is something that may *seem* important, but it is rather like an ornament or an idle wheel in a machine, it has no function (§293).

If we assume that the public character of language is a premise that Wittgenstein *brings into* the argument, then the quest becomes one of how it is possible to speak meaningfully about inner experiences without collapsing into a private language. We cannot allow that our account for understanding turns out to depend on a private language. This would actually imply that we couldn't understand each other even when we talk about sensations and feelings. The question is therefore *how* we are able to understand each other, and not *whether* we actually do understand.

Philosophical Investigations starts by referring to an initial inclination to view ostensive definitions as an explanation as to how words mean. We use ostensive definitions when we explain the meaning of a word by indicating, calling attention to, or pointing out something as the reference of that word. This is also a theme in the opening paragraphs of the *Blue Book* where Wittgenstein talks explicitly about the breakdown of ostensive definitions. He claims that simple words that are easy to understand, like 'length', 'meaning' and 'the number one', become over-complex so that it becomes almost impossible to account for their meaning based solely on ostensive definitions (Wittgenstein, 1958a). Wittgenstein does not reject that ostensive definitions actually establish meaning; however, he does suggest:

> If you describe language in this way you are, I believe, thinking primarily of nouns like 'table', 'chair', 'bread', and of people's names, and only secondarily of the names of certain actions and properties; and of the remaining kinds of word as something that will take care for itself.
> (Wittgenstein, 1958b:§1)

The claim that introduces *Philosophical Investigations* is that our natural way of perceiving language is too narrow to include every aspect of language. He follows up the claim with two examples of 'simple' language games. We refer to the first example as the 'shopkeeper'. The shopkeeper is handed a note that reads: "Five red apples". The reference of the expression is clear and appears simple until Wittgenstein recapitulates the rules that the shopkeeper actually follows in order to bring about five red apples.

We refer to the next example as 'the builders'. The builders have established a complete language consisting of only the four words block, pillar, slab, and beam. They express the words by referring to the building materials as they need them in their building activity. The expressions thus take part in the activity of building itself. The meaning of the words can only be understood within this context.

In these examples, Wittgenstein takes the idea of ostensive definitions seriously. If we assume that ostensive definitions explain why words have meaning in general, then we should be able to account for why the participants in the two examples understand each other.

However, why is it that when we account for the references involved in what we may call *simple expressions*, like the message to the shopkeeper, they turn into *over-complex* descriptions that are *difficult to follow*? This represents a disparity between the initial expression and its explanation. Furthermore, how do we account for everything that the reference does not account for? For instance, why does the shopkeeper put the apples on the counter when you say five red apples? Does he anticipate that you want to buy them? Does it always mean that you want to buy apples when you hand someone such a note?

In the example of the builders, the tacit meaning or understanding is in focus. The words do not simply point to certain objects; they also imply that builder A wants builder B to bring the named item. Consequently, the word does not solely refer to a thing, but also acts as a command that refers to the activity of bringing it.

Both examples focus on nouns and physical objects. It is therefore easy to see that to which the words 'point', and the activity that is involved. The simplicity of the examples is important because we clearly understand what is going on, and yet, the explanation by ostensive references does not offer a complete clarification as to how we understand the examples. Some aspects become hard to describe and, even more importantly, other aspects slip into the background and become tacit or hidden. Can we then say that ostensive definitions actually represent the fundamental account for why we understand?

In the private language argument, Wittgenstein looks at this ostensive approach to meaning concerning inner states, like perception, feelings, and emotions. The private language arguments should be seen as a reformulation of ostensive definitions. A certain view of language becomes problematic simply by evaluating how we may speak and understand what we say about inner experiences and sensations. If you follow the idea that words assume specific meaning due to their reference, then talking about inner experiences, perception, or sensation will lead to a private language. If talking about inner experiences implies a private language or definitions, then we actually have no language for inner experiences and consequently we cannot talk about these things in a meaningful fashion.

We could think we understand what the other says because we compare it to our own perception. On the one hand, on what ground could we assume that we mean the same with the same words (identity of meaning)? Even if we would consider identity of meaning as a necessary condition in order to know what the other is talking about, we will never reach this point. The position is not feasible. As both Rossvær and Hertzberg point out, to maintain such a criterion would presuppose God's perspective in order to compare the different inner experiences with each other. Without this perspective, we have no guarantee that we mean the same (Rossvær, 1974; Hertzberg, 1994). If we would like to maintain this position then understanding would be impossible, at least for us humans.

On the other hand, we should have no problems accepting that we understand what the other means when he/she says, “I am in pain”, or “this is red”. Such expressions are so trivial that we cannot accept a view of language that does not account for them, or that even might exclude them as meaningful, comprehensible expressions. Hence, if the view of language contradicts the possibility to talk about inner experience or sensation, then we have to revise what we think about language and not what we think about inner experience. This would otherwise represent a sceptical position that philosophy couldn’t maintain or survive. The ridiculous with this is not that we cannot establish unambiguous definitions or proof of what we mean when speaking of inner experiences, but that such efforts are even made. We already speak about these things. The question is therefore *how* we understand and *how far* we can express our emotions, perceptions, and other experiences.

We always talk about *something* when we speak. To make oneself understood or to see what others mean is a normal experience. In a certain manner neither meaning nor understanding are problematic. They belong to the everyday experiences of life. However, if psychotic experiences cannot be placed within a shared language, the expressions will have no meaning in speech. If we want to speak of psychotic experience, we might ask whether our life world is shared with the schizophrenic patient; or whether we only understand each other until a certain point where understanding eventually reaches its limit.

This becomes apparent when dealing with the language of sensations. Still, *meaning* as such is not revealed as mistaken. The mistake is more fundamental because what we *think* of meaning can be too narrow and thus must be reconsidered. This leaves the question of understanding psychotic expressions as an either-or situation.

- *If psychotic language were a private language, then understanding would be impossible.*

After all, the patients refer to sensations, experiences, hallucinations, and ideas that are extraordinary. The initial perception of difficulties of understanding would then be explained as a fundamental problem. Privacy could offer *one* possible explanation that could rule out understanding as such. On the other hand,

- *If the private character of the psychotic expressions doesn’t imply a private language, then we may ask how understanding them is possible.*

The clue is to focus not on what distinguishes psychotic expressions from other expressions, but what they have in common with other expressions that refer to inner experiences. How do we make ourselves understood? Moreover, why does understanding inner states even arise as a problem?

1.2. Language goes with a way of living

Rhees argues in the essay *'Can there be a private language?'* that a language cannot be private (Rhees, 1970:55-71). The public character of language is not questioned. Rhees wants, instead, to shift the focus from *privacy* to a theory of *meaning*. *Why* the language has to be public in order to be meaningful is another issue. Rhees argues that when words refer to things it is due to the way they enter the conversation.

> When we talk about something, our language does not point to it, nor mirror it. Pointing and mirroring could refer to things only within a convention, anyway: only when there is a way in which pointing is understood and a way in which mirroring is understood. I point for the sake of someone who understands it. Apart from that it were an idle ceremony; as idle as making sounds in front of things. (Rhees 1970)

The expressions are understood in the context of that which people say and do. Our expressions will be taken in one way or another whenever we speak. Rhees continues: "What we say makes a difference. If it made no difference what sound you made or when, you could not be understood and you would have said nothing." (Ibid.) For this reason, the act of expressing oneself cannot be imagined without meaning. Even misunderstanding or ignoring the speaker are ways of relating to the expressions of a person.

Rhees presupposes that language is something spoken. The question of meaning cannot be understood apart from the activity of speaking. The act of speaking involves the possibility of a listener that understands what is being said; therefore, language already transcends the private sphere in being spoken. If understanding transcends the private and making oneself understood is a part of speaking, then the issue regarding private language is really a question of how words mean. It is thus not the public character of language that is at stake in the private language arguments, but rather our *understanding of language* as such.

Another way of phrasing the questions that the private language arguments raise, according to Rhees, is to ask what the rules of language are. He argues that rules do not describe only regularity. ‘How words mean’ is really the question of how language becomes an agreement in the public sphere. Rules may be kept as secrets and even be limited to a single person; however, they cannot be *accounted for* privately. Setting up rules involves following them, which presupposes correct and incorrect application of the rule. If the rule were a private feature, then the decision as to its application would rest solely on the person him or herself. Rhees maintains that following rules signifies neither a *determination* nor an *agreement* with regard to what people do. To learn a rule is to understand how it is applied and to continue using it as the other person would use it. This leads to Rhees’ main point that ”Language goes with a way of living” (Rhees, 1970:64). To follow a rule represents the way a certain expression is being used, and this usage will always go with a way of living. The act of following rules signifies that language represents a common feature as long as what we *say* makes a difference to others.

Agreement in reactions is essential as an explanatory element that places meaning as part of human interaction. Rhees maintains that learning, understanding, and using words presuppose that our reactions tally. This is especially conspicuous when speaking of inner states since such references seems to be hidden. Learning the meaning of ‘red’ means that one is able to use it independently. We may say that one understands when our use of the concept matches the use of others. The sense or how words assume specific meaning therefore refers to the usage, and not to the (inner) experience of seeing red. He thus establishes *outer* criteria for *inner* states; nevertheless, it is not considered superficial.

The interaction that occurs in speech constitutes meaning or common understanding. Rhees argues that understanding belongs to this interaction. He thus places the constituting element as part of *outer* expressions and the *inner or private sphere* is seen as secondary with regard to conceptualisation. For instance, it does not matter what the actual impression red makes as long as our reactions to red things tally with those of others. I point to something red and she says, “red!” When learning the word our reactions to the same expressions will start to coincide.[12] What she actually sees doesn't matter; we don't need to know that for the sake of understanding what she means. It is an idle wheel when accounting for what we mean.

Rhees claims that we may recognise colours and know what word to use by such private definitions; however, the correction of its use is based on interaction in speech. It isn't necessary to see the sunset as the other sees it. Saying that the sun is blue is incorrect under any circumstances. Correct and incorrect use of the word refers to the interaction and not the assumed sense impression of the colour. We correct each other through speech only.

The experience of the sunset to which we point is something we have in common. Explaining my impression of the sunset to a child that is born blind does not provide an easy access to an assumed equivalent experience. According to Rhees' analysis of the private language arguments, we cannot assume that we see the same under any circumstances. However, in the case of a blind child, noticing that we do not have identical experiences is inevitable and it may strike us as problematic. This does not mean that it would be pointless to bring the blind child to the beach at dusk, or that it would be impossible to speak about our experience.

The difference in our way of living and that of the patients is not that significant. We share the vital goals or the direction towards continuance of our existence (Heidegger). The trivial matters that rehabilitation reintroduced offered wider possibilities to relate to the life world of the patients. To have similar everyday concerns points towards a shared life world, which made it not only possible to speak *about* something, but also actualised these conversations. Trivial matters could represent serious problems for the patients; therefore, the trivial becomes an intersection in which the impact of the illness is manifested.

This made it easier for the staff to identify with the patients and to take their side. The staff knew *why* the inhabitants liked to dress in certain manners, why they didn't like to go out, and why it sometimes was impossible for some of them to maintain a sound private economy. Their closeness to the patients' way of living, through the intersection of the rehabilitation unit, also represented a context in which the 'larger' and 'deluded' ideas could be related and where they could make sense. The uncovering of a common life world establishes a basis for expressing

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[12] Watching a sunset, a child may say, "the sun is blue". Even if we assumed that the actual sense impression of red equals my impression of blue, this would not matter as long as she has the same impression each time she sees red.

oneself and understanding the other. We could of course object that the insight or empathy soon reaches a limit. The next question is then whether this limit is different from other expressions of inner experience.

1.3. Private experience and its language

Stanley Cavell claims that little is said within the private language argument about both privacy and language that has not been stated more clearly in other passages of *Philosophical Investigations*. Cavell does not reject *privacy* as a legitimate issue. He does however claim that the private language arguments do not introduce anything new and that they in fact change a simple point about language into an elusive discussion. He criticises the proportion this argument has been given in the literature, which he thinks suggests that the arguments have been miscast (Cavell, 1979:343).

The question here is whether the problems connected to understanding psychosis make this language collapse into a private language or not. The privacy is in that case a result that forces the patient into solitude. This point was made relevant in relation to Rhees view of the private language arguments. The approach of Cavell is also interesting because he removes the focus from privacy to understanding. He maintains that the public character of language is a premise that Wittgenstein brings *into* the argument, and by that he bypasses the *argument,* but not the problems regarding *privacy*. The conclusion is not *brought about by* the argument. The problem of privacy, however, arises especially with regard to *understanding* the other (Cavell, 2000:22-24).

The sceptical attitude that Cavell advocates does not imply denial of something, but simply acceptance that certain questions about knowledge cannot be answered. To label an argument sceptical, it is sufficient that it runs roughly "So we don't know (on the basis of the senses or behaviour alone); then (how) do we know?" (Cavell, 1979:46). The sceptical position is the claim that one should continue regardless of whether we have answered the question affirmatively or negatively. The elusiveness of inner experiences does not present any new or principal problems. Cavell takes one further example from Wittgenstein in *In Quest of the Ordinary*:

> Other people cannot be said to learn of my sensations *only* from my behaviour – for I cannot be said to *learn* of them. I *have* them (Wittgenstein, 1958b:§246).

Cavell maintains that every philosopher that has investigated the sceptical question of how we can know of the existence of so-called other minds has found him or herself saying something of this sort, that others know of me at best from my behaviour. It is as if a 'behaviouristic' position were the only alternative to mind reading and telepathy.

Cavell presents two major objections. First, he believes "... that we cannot speak of someone learning of our sensations only from our behaviour without *insisting* that the words speak the obvious truth" (Cavell, 1988:163). Second, he reckons it as a devaluation of behaviour to view it as a *problematic* access to the other mind. It is as if understanding fails to reach the other mind because it can only turn to behaviour. The phrase 'only' suggests a disappointment in behaviour as a route to knowledge about what is going on in me. It is "... as if my body stands in the way of your knowledge of my mind" (Ibid).

Wittgenstein describes the inner in terms of both the familiar and the mysterious. Expressions like "Who knows what is going on inside him!" (Wittgenstein, 1980:2,§643), presupposes that something is accessible for the person himself, but hidden from all others. He continues by asking whether I would know that pain was something inner if I were not told so. Even if one did not know to place it as an *inner* experience, one would still have the experiences that determine the notion of the inner. The inner is closely related to the claim of the experience as *one's own experience*. The sensation of the pain is immediate; "I am in pain, because I feel pain". The pain of others is not accessible in the same manner as my own; and yet, I feel immediate compassion and empathy when witnessing the behaviour of others who are in pain. People may also claim that there is something wrong with me if I do not feel compassion when witnessing the pain of others, and yet the experience of pain is not the same as if the pain were my own.

Johnston argues that Wittgenstein attacks the notion of the *inner*, not in order "...to reject the idea of inner experience, but to undermine an incoherent account of the nature of that experience" (Johnston, 1993:17). The problem of the *inner* is that it cannot be accounted for apart from *outer* expressions. There is therefore a connection between the inner experience and its outer expression. "Without this connection, there would be no way of bringing language and the experience into relation with each other" (Ibid, 24). He concludes that the argument implies that the language of the *inner* does not build on rules, but on *natural reaction*. Moreover, being a reaction, it might also be seen as an immediate expression of the *inner*; it is an expression that will place the 'inner' in the 'open'. Maintaining the importance of natural reaction explains how inner states have outer expressions and how we, by that, have *immediate access* to the inner states of the other. Taking the outer expressions as the clue for revealing inner qualities does not transform or neutralise the inner life into merely *outer* properties. The denial of the inner, which was seen as essential in behaviourism, presupposes exactly the division between inner and outer that Wittgenstein rejects. The potential is that the inner is made accessible to understanding not only as introspection, but also from the point of view of the onlooker.

This suggests a limitation of understanding since we face the possibility that a part of the inner life cannot be expressed, which means that we cannot account for it. The only way to overcome this problem when addressing others would include the necessity of *becoming* the other in order to understand. However, this would neither account for opaqueness of introspection nor the relation to others since it demands an impossible condition as the premise for understanding. It would therefore not only rule out the possibility of understanding some aspects of the other, it would also rule out understanding in general. Psychotic expressions just make an already tacit condition of understanding conspicuous. The fact that we do not share certain inner experiences with the patient does not imply that speaking of these experiences represents a private language. We have not 'lost' anything from this position, other than a misconception about language one initially and erroneously assumed.

1.4. Inner states and outer expressions

Hertzberg (1994) argues that Wittgenstein's private language argument is one of the most difficult parts to understand; nonetheless, he regards it as a necessity to enter his later thought. He thus gives the private language arguments a more central role in contrast to Cavell. The discussion raised is rather complex, primarily because Wittgenstein wants to challenge the entire way we think about thought and meaning. The question focuses on how we evade the problems of privacy when referring to inner states. How do we deal with inner states with words?

Hertzberg confronts the problem of meaning by raising the question as to *how* an expression is connected to the phenomenon, the object, or the situation, which constitutes the meaning of uttering the expression. He opposes the assumption that these designations could be clarified using general formulations to define what we mean. First, this does not explain the expressions used in the definitions. Eventually a connection must somehow be established directly between the linguistic expression and the actual instances of their application. Second, inner states present the problem that the object to which we refer seems hidden to everyone but the speaker. We thus have to search for another possibility:

> Hence, it appears, in trying to establish what an expression means we are eventually thrown back on observing the particular situations in which speakers use expressions. (Hertzberg, 1994:18)

Particular instances cannot by themselves determine what the speaker means. Learning what the other means depends upon an ability to transcend the particular situation. When someone utters a simple expression like pointing to an object, it can be taken to mean a number of things depending on the situation. The meaning of the speaker is not determined simply by looking at the object. Hertzberg argues that even a simple act, like showing a picture of a boxer, could be used to indicate many things, as, for example, telling someone how to stand, or how *not* to stand while boxing. It could be a description of how a particular man actually did stand, and so on. The context of the conversation will determine the meaning of referring to the picture.

The speaker's meaning is therefore not established simply by pointing to an object. Pointing could represent a description of any quality like shape, colour, number, its function, and so on. If I am pointing to a red square, how do you know whether I am pointing to its redness or its squareness? Moreover, even if we could agree on a category, say colour, what exactly defines the meaning of the 'colour-word'? What qualifies it as a sample of that particular colour? Understanding assumes that we have certain things clear before we start to define our concepts. We will need en entirely different approach to define our concepts.

I cannot learn the concept "red" by simply looking at red objects. Let us say that someone shows me an object and says: "This is called red". How do I know the proper application of this concept? Is it the shape, the colour, the act of showing something, or what? When a child learns the use of this concept, she learns how to apply it in specific situations. I can show her a red apple, a red book, a red sunset. Gradually she will be able to use the concept correctly and connect it to other objects and other contexts. Then we will say that she understands. To have a concept is not just to look at 'red' things; it is to know how the word 'red' is being used.

This does not mean that she now understands the entire use of this concept. It will perhaps come as a surprise to her that some politicians are called red. Does knowledge of the colour red signify the meaning of 'red lights', 'red alert', or 'red light district'? Does 'red' signify the same in a traffic light, watching a sunset, or in a darkroom? Instead of being an arbitrary use of the concept, it represents different kinds of usage that reflect the variety of a language-game. Rules may offer some problems. For instance, regular use may be too stiff to accommodate every aspect of a language game. Rules may not determine what we say; however, because when we understand what is said we are able to recapitulate it by rules. We see the pattern, the overlap between different usages. Rules become reflections of the regularity and tallying reactions.

When speaking about inner states like emotions, speech does not represent or fully describe emotion, however, speech may *express* emotion. In the discussion of pain, Wittgenstein says that 'I have pain' has meaning as pain-behaviour similar to other behaviour like crying or moaning. We assume that the expression is accompanied by a sensation. What is the sensation that accompanies the expression? Here we approach the limits of what can be said clearly, although it is possible to describe or explain how we feel. Take the happy couple that declare their love to each other. How can she be certain that his feelings for her equal her feelings for him? She can surely describe certain standards. However, whether they meant what they said will be indicated by their life, how they relate to each other. The expression just states that which already is at hand.

According to Hertzberg, the public character of language does make it impossible not only to imagine a private language, but also to imagine the 'solitary speaker' (Hertzberg, 2003b). Speaking without a listener would be an empty activity. Imagine the builders giving orders to themselves. Uttering orders would have no point, they could just as well have mumbled or remained silent. The situation is fundamentally different when A addresses B. The expression is part of a joint activity of building. It serves a purpose, even if the building activities might have proceeded without these orders. Uttering the words in this context makes sense in opposition to the words of the solitary builders.

The problem that we do not always have expressions to say completely how we see things is not limited to psychosis. Language marks the limits of human experience; however, it implicitly urges us to see further. The question is then how can I learn new things and come to share and understand life worlds that are different from my own. It is not a question about exceeding the limits of language, but of exploring how far we can go. On the other hand, what are the implications of this when talking about psychotic experiences? Psychotic expressions may seem absurd and bizarre; it is often obvious that our reactions do not tally. This points towards two important aspects of language:

- *It becomes obvious that we use concepts differently.*

- *It becomes obvious that we do not see what is going on 'inside' the other.*

However, if we are to take the private language arguments seriously, then these aspects have no part in understanding the other and the ability to speak of inner experiences. If this were not the case, then we would not be able to express and understand 'ordinary' experiences like pain, colour, and emotions. The private language arguments thus articulate a problem that is not limited to psychotic language; however, it does indicate how a too limited perception of understanding may fail to see an already present potential in the interaction with the patients.

The intention of introducing the private language arguments of Wittgenstein in this context is to inquire into one way of thinking in which psychosis may become incomprehensible. The inquiry of Heinimaa is based on how the word is used in everyday language. There are certain features of psychosis that indicate that psychotic expressions are incomprehensible and its possible private and withdrawn character is therefore worth considering.

Privacy may be understood in a number of different ways. Associations may go in the direction of being personal, individual, or special. To withdraw into privacy is as 'shutting the door' behind oneself, being alone, having peace and a quiet time to think. However, when Wittgenstein turns towards privacy, it consists in *being* shut off, or of states that are hidden from others. It represents something that only the person him or herself may see. Wittgenstein turns this idea of privacy against itself. First, if words like 'pain' in fact where referring to inner sensations without outer references, there would be no meaning in using the word. Second, to claim that words like pain acquire their meaning from outer references, such as moaning and twisting, would be absurd because pain is something immediately accessible. Consequently, privacy in this strict sense does not account for the way we actually speak of sensations and inner states.

The private language arguments illuminate a context in which it is *not* meaningful to express inner states and sensations, and thus point to how we in fact do make ourselves understood. Disregarding psychotic expressions because they are inaccessible and because they are inner and private, is based on a false idea of how speaking of 'ordinary' ideas and sensations actually is meaningful. Language places that which we talk about in a public room. Language thus implicitly transcends privacy.

Through the private language arguments, Wittgenstein encourages a sharpened consciousness of the context that actually makes it meaningful to speak of sensations and inner experiences. In this respect, psychosis does not represent a unique position, although it might include (highly) private experiences and extraordinary ways of expressing oneself. Just for that reason, the private language arguments call for an effort to take their expressions seriously and to put them in a context where meaning at least *could* be possible.

2. LANGUAGE BEYOND THE PRIVATE SPHERE

Talking about inner experience raises questions regarding what we can and cannot do with language. Although the expressions may be part of an experience, the expression neither recreates nor replaces the experience in any way. However, we may act in accordance with the expression itself. On the other hand, we have circumstances in which the meaning of a good expression might remain uncertain. Is it possible to know exactly what I mean without being able to say it?

2.1. Within a complete language

> Let us imagine a language for which the description given by Augustine is right. The language is meant to serve for communication between builder A and an assistant B. A is building with building stones: there are blocks, pillars, slabs, and beams. B has to pass the stones, and that in the order in which A needs them. For this purpose they use a language consisting of the words "block", "pillar", "slab", "beam". A calls them out; - B brings the stone which he has learnt to bring at such-and-such a call. Conceive this as a complete primitive language. (Wittgenstein, 1958b:§2)

Completeness signifies in this context, that this primitive language is to be taken as the entire language the builders have at their disposal (Wittgenstein, 1958b:§6). We must therefore presuppose that this language can stand alone as self-sufficient and determined. The language of the builders consists of four words related to the activity of building. Many have regarded it as a mistake of Wittgenstein to claim that we could accept this as a *complete language*. Sarkar repeats the claim of Rhees, that if the builders think only these four words, they hardly speak a language. The builders thus cannot be considered human, unless we imagine 'expressionless thoughts'. The objection is therefore not whether this can be considered as a *complete* language, but whether it is a language at all. Sarkar adds that the language is too primitive to be conceived as complete (Sarkar, 1985; Rhees, 1998; Rhees, 1970:71ff). Cavell also refuses to accept that the language of the builders can be regarded as a language. It is impossible to imagine a so limited language and at the same time conceive it as being complete. The people involved will have a so limited life-world that they hardly can be called human (Cavell, 1996:288).

Cavell and Rhees make an obvious point. The drawback is that they do not say more about the example in itself. The builders hardly appear human. They build, at least as long as they use this language. A complete language does not exclude the possibility of expansion. This is an important point when evaluating the example since what the builders *cannot* say becomes more conspicuous than what they actually *can do* using their language. By reducing language to almost nothing, Wittgenstein makes it inevitable not to think of what lies *outside* the limits of language. The criticism of the example is consequently based on all that the example does not include. The example becomes so plain and distinct precisely because of all that is left out.

Wittgenstein opposes the notion of language that he attributes to Augustine. Rossvær argues however that the quotation doesn't represent Augustine's view of language. Rossvær says that Augustine's quotation describes how Augustine learned to *write*, and not *how words mean*. Rossvær also claims that Augustine has far better accounts for language than the passage Wittgenstein chose (Rossvær, 1998). Rossvær argues that this might be an intended tactic by Wittgenstein in order to uncover an *underlying misunderstanding of language* that is exhibited when we account for particular settings like that of writing. It represents a disparity between how we use language and how we *account for* language.

The strategy of Wittgenstein is nevertheless to assume that Augustine was right, and that *ostensive definitions* constitute the basis for a complete language. Would we miss anything? The consequence of the effort to take a certain opinion on language seriously exposes all that we cannot do within this language. Therefore, when Wittgenstein tries to imagine that the language in §2 is the *whole* language of the builders and perhaps an entire tribe, the events take an unfortunate turn. It becomes obvious that the builders *cannot* say, and thus cannot do, many trivial things. How could, for instance, A express affection or love towards B? Would it be possible for A to compliment B on excellent work – or yell at him for badly performed work? Is there a *better* way for B to bring the building materials? Could A tell his children at dinner what he has done at work?

If the language of the builders is complete, and we assume that they are humans, then one should suspect that feelings of affection could develop between them. In addition, they would feel pain as we do, and yet they wouldn't have a language to deal with that. Could affection be imagined if it weren't expressed in any way? Would we be able to speak of love apart from language? What will happen if they hit their thumbs? We should assume that they still feel the pain, and express it like animals; however, they would lack the words to express it. The pain would be real, and the scream would be mere pain behaviour. A would know what was going on with B. They are like animals, except for the possibilities that these four words represent. The behaviour would offer an immediate understanding that the other is in pain, even if the builder lacks the opportunity to replace the behaviour with words like 'I am in pain'.

The claim of completeness implies that the language serves its purpose as part of the activity of building. It is not necessary to explain it, or derive it from another language. On the other hand, the claim of completeness limits the language to this purpose. It has to be extended to be able to deal with other functions. The example is so primitive that its limitations are more obvious than its possibilities.

Possibilities of utterances are thoroughly examined in the private language arguments and the topics that are related to inner experience. For instance, we may lack the proper words to describe the taste of coffee, the sound of the clarinet, or the sensation of pain. The idea of describing the aroma of coffee raises a whole line of questions:

> Why can't it be done? Do we lack the words? And *for what* are words lacking? – But how do we get the idea that such a description must after all be possible? Have you ever felt the lack of such a description? Have you tried to describe the aroma and not succeeded? (Wittgenstein, 1958b:§610)

What we can do, however, is to say: "this tastes like coffee", "this must be the clarinet-solo", or "I am in pain". While referring to the actual taste or impression does not fall outside the limits of language, it is doubtful whether it represents how we actually interact and share impressions and experiences. It is therefore hardly a problem for us.

The language of the builders is in fact *limited*, and yet, it is sufficient to direct the building. The builders cannot even count in §2. The need to bring several identical building stones may arise. It can be executed within the existing language by repeating the order. Alternatively, Wittgenstein demonstrates how the language may be *expanded* to deal with numbers and direction (§8). It is possible to imagine further expansion of the original language-game. (Wittgenstein, 1958a). The new extended language is more advanced and still complete. Adding the function of numbers and counting does not add anything that could not be done in the original language-game. It is perhaps more practical and efficient to say a number, instead of slab, slab, slab. In this way, we could expand the language by adding functions that are used as we build. We could also imagine the language expanded to include other areas like expressing affection, describing situations, indicating colour, offer complaints, and comfort. All the time we know that *'there is more'*.

Wittgenstein demonstrates a limit to possible expansion in the examples of inner states. Even simple and everyday experiences that we have no problem dealing with cannot be fully described or explained. The main questions remains: Given the language that we actually possess, do we miss anything? Wittgenstein does not offer any meta-language that could account for what 'missing' anything would be. Discussion of language must take place within language. He thus offers examples that manifest limits of what we are able to do with language. Furthermore, understanding does not possess any meta-position from which we could evaluate the responses of participants. Our reactions could agree and we might be certain that we have a common understanding; however, we can not guarantee that something should happen suddenly so that it becomes evident that we use our words differently, or that we simply did not mean the same.

The difference in experiences is eye-catching when it comes to psychosis. Although we may never have tried to describe the aroma of coffee and not succeeded, it is likely that the patients have tried to describe psychosis and failed to do so. For that reason, it is important to ask what kind of language can possibly deal with those experiences. What would an adequate description mean? Can the patients make us see what it is like? How can a person be able to separate hallucinations from 'actual' impressions? Is there a kind of language that deals with sensations that can also deal with such instances?

Møller & Husby think that difficulties with verbal communication are explained by the nature of schizophrenia and the experiences of psychosis as such. They refer to Sass who claims that even the most articulate people with schizophrenia can usually do nothing but helplessly repeat the same, hopelessly inadequate phrase: All seem so foreign ... everything is sort of different (Møller & Husby, 2001; cf, Sass, 1994).

The informants on the unit were reluctant to talk directly about their psychotic experiences. This was partially because the psychosis was connected to experiences of personal breakdown and collapse, but also because reporting and having psychotic experiences influenced their continued life within or outside the institutions. In addition, there were difficulties in articulating and thus comprehending the psychotic experiences as such. It was as if there was no easy way to make others see: "This is what it is like!" or "That's why it happened."

Stories of the initial crisis were often incoherent and fragmented. The explanations, descriptions, and experiences themselves did not always coincide. The impression gained from the descriptions was almost that of a dream state in which the patient in retrospect also was not sure what was real and what was not. Some said that they were much more aware of what happened around them than usual. Others saw and heard things that they simply did not understand. Even the most comprehensive efforts to share something about the experiences seemed to be only disconnected and fragmented expressions and descriptions.

The experiences as such challenged the limits of the language. The stories often exhibited creative use of concepts and stories, and frequently resorted to the use of metaphors. However, if this represents failure or inadequate accounts, what would we expect from a successful description? What kind of concepts do we miss? What is it about designations like 'strangeness' that is inadequate? If we in advance do not know what the patients are talking about, how can we say that a description is insufficient. The problem demands that we in advance know what we are looking for and what a good description would claim from us.

2.2. Knowing what I mean

> The quality of uncanny particularity does not attach primarily to the realm of private images or sensations but to what is, from the standpoint of both observer and patient, the real or external world (Sass, 1994:98).

Louis Sass emphasises the problem of saying what we mean in relation to psychosis by what he calls 'uncanny' or 'mute particularity' (Sass, 1994:97). Sass emphasise the 'private' character of the schizophrenic mind, and maintains that it demonstrates a solipsistic attitude toward the world. He argues that the delusive mind will face the same contradictions and difficulties as the solipsist. The 'uncanny' experience or 'mute particularity' is a complex feeling of alienation and awareness. He applies these features to what Paul Daniel Schreber says about some of his experiences. The memoirs of Schreber account for himself, his beliefs, and his experiences in detail. The memoirs were written as a part of applying for dismissal from hospital. It was published at the end of the 19th Century.

The memoirs are filled with peculiar descriptions; however, Schreber demonstrates extraordinary skills in accounting for himself. The clearest impression this book gave me, as a reader, is that of a man who is utterly isolated and withdrawn. At one instance, he describes standing in the yard at night. He sees the lights of Leipzig and wonders whether the city still exists. He moreover describes a universe in which he questions the existence of the world and other people. He also describes the battle between himself and the psychiatrist, a battle to which he gives universal proportions (Schreber, 2000).

The experience of being isolated from everything and everybody may also substantiate Sass' *stronger* claim of a kind of 'solipsism'. However, Sass is particularly interested in the concrete reports of sensation like those Schreber describes when he sees himself changing into a woman, how he hears the birds talk, and a particular experience that he names the "wasp-miracle". Schreber describes how he produces the miracle. Sass takes notice of the 'elusive' manner in which Schreber substantiates this claim by referring to the miracle itself, by the particular way the wasps are manifested, how they move and how they disappear. Schreber describes himself as sitting still on a bench. The wasp appears in front of him. However, instead of appearing randomly, he argues that they were manifested in a *definite* pattern, although he does not and cannot elaborate on this any further. Schreber sees the account of a definite pattern as proof that the wasps are upheld by his mind and do not exist independently. Sass argues that Schreber's proofs are loose, especially those of the pattern. The most concrete proof he gives is that the wasps always appear three times. Sass defends the position of Schreber, saying: 'the events *felt* definite to him'. Sass argues that Schreber is not withholding any information or descriptions of the patters; it seems rather that his experience of *definiteness* could not have been described more completely.

> What seems to overwhelm him is just the sheer and, in a sense, abstracts fact of the specificity or particularity of everything around him (Sass, 1994:100).

Instead of attributing this to *Schreber's* lack of ability to describe the experience, Sass perceives the problem … "to be bumping our heads against the limits of our language [as Wittgenstein would say]" (Ibid). Sass also thinks that this indicates a common feature when dealing with schizophrenic patients, and that Schreber's ineffable definiteness is a central and characteristic feature of this kind of life-world.

The situation is thus distinct for schizophrenia, but my question is whether it refers to the manner in which we share inner states and experience as such. Certain experiences are difficult to articulate. This is not remarkable; neither is it especially remarkable to connect this to experiences of schizophrenia. The concern, however, is to rehabilitate these experiences as a normal part of language. Sass does that by seeking support in Wittgenstein; although he admits that this cannot be done without challenging the perception of meaning which is characteristic of the later Wittgenstein's treatment of the way expressions make sense. Indefinite expressions like “stand roughly there” make sense. Even though a definite position is not clarified, there clearly are positions that are correct and incorrect in relation to the utterance.

There is another aspect that emerges when we speak of inner experiences which is especially evident with regard to experiences we cannot presume as shared. When we want to describe something, the object we describe seems to transcend even its best descriptions. This does not necessarily mean that we do not know what we mean or that the object exists independently of the descriptions.

2.3. What he meant and what he said

Rhees describes the mistake in confusing the ability *to say* on the one hand, with how I *identify or refer to the sensation* on the other hand. Does this distinction correlate to problems with accepting descriptions of psychotic experiences?

Rhees says that seeing red gives me a particular sensation. It is hard to deny that I connect some sort of experience to the word ‘red’. Rhees continues, “I know what *I* mean by ‘red’. It is what I experience when I look at this” (Rhees, 1970:58). In a way, the person has given a private definition of what is meant by red. However, it does not represent a private language, because the use of the concept is regulated in actual usage and thus in interaction with other people. I could establish the definition in this manner without being able to know whether the definition is similar to the experience of other people in similar situations.

If one wanted an elaboration of what the word ‘red’ might refer to, it is tempting to ask, “What do you see, then?” The response to this question could either be to repeat the word (“I see red”) or to display a sample of what I see (“I see this”). So, what is the sense of ‘ the colour red? If it is something nobody can say, then it must also be the case that nobody can ask for it (Rhees, 1970:58). It would be impossible to talk about colours, or sensations all together, if this were true. The reason that we actually *do* speak of sensations suggests that meaning transcends the private definition. It is thus based in the *shared use* of the concept. It will come to expression when the concept is misapplied or misunderstood. If a child says that the sea is red, I will correct her without even considering whether her impression of blue or red differs from mine. I know when something is red, because I recognise redness when I see it. I can remember the colour I saw, and I can identify it as the *same* colour; however, the meaning of the concept is connected to its shared use and not to sensation itself.

If the meaning of words referring to sensations is established solely via ostensive definitions, then we would have a private language. Others cannot understand this language as long as nobody knows what the words refer to. Neither can it make any sense to the individual. If we want to maintain that we can speak of sensations, the naming-theory fails to give any account for *why* that is possible. For that reason, we must maintain a view of language that can deal with these objects.

What is then the problem with speaking of psychosis and psychotic experiences? Does it differ from the shortcomings in descriptions of taste and descriptions of colours? It is possible that a misconceived idea of access to inner states sneaks into the evaluation? On the other hand, although the use of concepts of colour does not refer to the inner state as such, we can assume that we have a shared experience of red things. This is different with regard to psychosis; however, to answer whether there is a fundamental difference we must look into how an inner state can be regarded as something we have in common. Can I only make you see what you already know?

2.4. Understanding other people's emotions

> If I, on the other hand, reserved the word 'pain' to what I hitherto called 'my pain', I would do others no injustice, but I would not have gained any insight into how I understand others (Wittgenstein, 1958b:§403).

Wittgenstein claims that utterances such as "I have pain" cannot be taken as a description of the pain. They refer to neither an object nor a fact. Instead, he suggests that the notion 'pain' should be seen as an *expression* of pain, as when pain is expressed by recognized painful behaviour such as moaning, twisting, and crying. The verbal utterance 'I am in pain' replaces crying and does not describe the pain (Wittgenstein, 1958b:§244).

In order to see the utterance as a *description* of something, for instance an inner state, it is necessary to separate the utterance from the pain. We then have to account for exactly what the description refers to. As an *inner* state, however, the pain is hidden from us. I do not feel the pain of the other as I feel my own pain. On the other hand, as we are willing to speak of the possibility of *simulating* pain, we assume that an inner state should accompany the expression (Wittgenstein, 1958b:§304). His example of pain directs attention to a fundamental point about communication. We react immediately with compassion to the cry of a baby. To react with the expression of care, for instance, does not need any other explanation than the expression itself: 'I picked up the baby because he was crying' or one could even blame the other: 'why don't you do something, can't you hear the baby is crying?' To witness another person's expression of pain gives an immediate understanding of the state of the other, and the response stands in a direct relation to this expression.

Every person has a first person experience with pain. This is not the case with psychosis. We could assume that we understand the concept pain because we compare it to own experience with pain; despite that possibility, Wittgenstein argues that this does not play any crucial role in the language-game. First, we then would have to assume that *my* pain equals *yours.* Although one would not do the other person any injustice by assuming this, making it as a criterion for understanding would imply a kind of overview of the other mind that took God's perspective (Rossvær, 1974:246). Second, Wittgenstein argues against separating the expression of pain from the pain itself (Wittgenstein, 1958b:§317-8). *The person who* is in pain and the *pain* itself are connected to its expressions (Wittgenstein, 1958b:§404).

How do I know that another person is in pain? The first and third person experiences of pain are dissimilar. If one witnesses pain behaviour, one will *know* that the person either is in pain or simulates pain. The first person experience is different. I do not infer that I am in pain from my own behaviour. The sensation is immediate; I do not need my outer behaviour to be certain of the pain, and if I do, it is unlikely that it is pain.

Although the 'outside' perspective is different, it is still immediate in its own respect. An officer told about a friend that stepped on a landmine during a minesweeping mission. They arrived at a known minefield and his friend stepped on the mine the moment he stepped out of the car. He was lucky, because this particular mine was not properly armed. Only the fuse detonated. It burned a hole in his boot and scorched his foot. He would have lost his foot if the mine had exploded. The field was later cleared of almost 30 mines, and this turned out to be the only mine that was not properly armed. However, the shock of actually having stepped on an antipersonnel-mine and experiencing more luck than one could hope for, was perhaps harder than the physical pain itself. It took some time before he realized that he actually was not maimed. His friend said that "He started to run, and ran all day, just to *feel* that he still had two feet. Then he sat down and wrote his application for dismissal." The other officer had no problems understanding the need to run, nor why he wanted dismissal. He could however also understand why the friend never delivered the application; although he did not know how *he would have reacted if he were in his friend's situation.*

The perspectives of these two friends are in fact different. It is one thing to step on a mine, and another to witness it. The connection between them should still be clear; however, it would be difficult to explain the connection solely as recognizing one's own sensation. It is rather a form of identification where one sees the situation from the standpoint of the other.

The difference in perspective is even more striking when those of us who have never experienced anything like psychosis consider the case of schizophrenia. In addition, some of the expressions of schizophrenia *suggest* an outside perspective to the patient, like voices that nobody else can hear or ideas that no one shares. The situation of expressing the experience of schizophrenia should be no different from expressing the experience of pain or any other personal experience, except that the difference in life form and experience is far more eye-catching with regard to psychosis.

The clue is the experience of staff in psychiatric or clinical practise. Even if the empathy builds solely on natural reaction, it is difficult to see how we could assume that it is a natural reaction without assuming that it involves understanding. In that case, we have an approach, not primarily regarding the problem of privacy, but to the question of achieving access to an understanding of the psychotic patient. This does not mean that understanding does not have its limitations and difficulties. However, it is not our ability to understand psychosis that is tested, but rather what it means to understand in general. This limit is not in principle connected to psychosis, but to the ways in which we refer to inner experience in general. The advantage with psychosis is that this limit becomes more eye-catching because we know that we lack comparable experiences. However, if we are to take the consequences of the private language arguments, then we have to assume that we do not understand because we refer to similar experiences. In that case, any reference to inner experience will collapse into a private language. On the other hand, if we connect understanding to natural reaction and interaction, then there is no reason to assume that we cannot refer to psychotic experiences.

3. SELF-PERCEPTION

Being a person is connected to the notion of uniqueness. One person cannot simply be replaced with another. Seeing the other as a goal-oriented, autonomous agent is essential to seeing the other as a person. How does this kind of uniqueness come into being? One solution is to look into how human *interaction* confirms or denies the uniqueness of the other person. The possibility that human interaction may *deprive* a person of his or her uniqueness is especially crucial, because this will undermine an essential aspect of being a person.

3.1. Loss of identity

Stories of illness were often told anecdotally by both patients and staff members. The perspective will be different depending on *who* brings the information. These stories have three important standpoints: the patient, the family,[13] and the clinicians. The stories could illustrate instances of how difficult life had become, or how people treat them in different kinds of situations. Stories could also refer to certain sensations or types of situations and even to particular instances that could articulate something more about what it is to be ill.

> One of the informants at the rehabilitation unit expressed the sensation where he felt all the eyes of the others on him; he could *feel* them think badly of him. It built up until he could not stand it, so he would have to leave. He continued by talking about taking the bus a couple of days ago, and having to leave after two stops because of this undefined eerie feeling of the glance of the others. (Field journal)

How was the experience of *becoming* schizophrenic told? The patients gave the best description of change themselves. The change was described on a timeline of *before and after* the outbreak of the illness. This applied despite the fact that the change from being well to being ill was often described and experienced as a gradual change. Eventually, they may find it almost impossible to carry out trivial tasks. The subsequent situation offered radical change in working conditions, as well as in relations to friends and family.

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[13] The family-aspect is not included in this fieldwork.

> [The informant] brought up the future as topic, but only became sad, because although he did not ask for much – a girlfriend and a life outside the hospital – he did not believe he would be able to achieve even that. He continued: "All my friends have established families and homes. I am just sitting here. All my life passes. It is thrown away." (Field journal)

Common to these stories are that they are very closely connected to *who* the person perceives him or herself to be. One is tied to the entire situation and to the illness; and thus to the institutions, treatment, and staff members. The clear impression is that schizophrenia is not described as something that one has; it is something that one has become. This close connection between persons' self-identity and an illness is nonetheless not unique for schizophrenia or mental illnesses as such. Certain descriptions of illness may become part of the identity of a person. For instance, it makes sense to say that 'I am a epileptic'; 'I am …' because 'I have it'. However, you would not say that you are your cancer or heart condition even if these may also represent instances of chronic illness.

The identity articulates who 'I am' reflexively (one's self as object) and in relation to others (social identity). Schizophrenia is thus a social, but also a reflexive process that entails alienation from who you perceive yourself to be. Even though the alteration is expressed as sorrow above, it is so because of the loss of qualities and abilities that deprive him of dreams, ambitions, and possibilities in life. Schizophrenia alienates or cuts the person off from ones own hopes for the future. Even modest dreams and goals seem unrealistic. It is an alienation from who you perceive yourself to be. The identity is being 'swallowed' by the illness.

The staff members, on the other hand, do not really have any first hand experience of a change. Usually they meet the patients after they have become patients, therefore they do not have any notion about how the person was before the outbreak of the suffering, apart from the accounts from the patient and relatives of the patient. The change that is seen is rather that of worsening and not of becoming ill. Another important, limiting factor is the conviction that the person lacks insight into one's own situation; therefore, the person's competence in describing what happened before is disqualified because of the illness. DSM-IV speaks also of confusion with regard to identity.

Information about first hand experience of psychosis was very personal and sometimes extraordinary. One informant talked about a change and happenings, but remained uncertain of the reality of the experiences. The uncertainty was not primarily a worry that she remembered it incorrectly, but insecurity as to whether or not *this* experience was *her own.* Experiences like that of escaping one's own body or context, or again experiences through dissociation do not necessarily contradict identity. They actually refer to the person. On one occasion, an informant spoke about a past that was remembered as something that happened to somebody else. It was remembered as something that he had seen, rather than his having a first person perspective of it.

In another narrative, the informant referred to experiences during the most critical times of his life. They were so lifelike and vivid that he was sure they were real. At the time of the interview, he remembered the experiences as so strange that he was not sure that he remembered correctly; moreover, he indicated that it was difficult to find words to adequately describe them. . On the other hand, the experiences are reported in first person. '*I* was watching *myself.*' '*I* am not sure whether this is something that *I* have experienced.' The point is that the question of who I am represents simultaneously a problem of self-alienation. The experience of psychosis, or the near psychotic, may be so strange and elusive that it in some respects does not belong to me. At the same time, it is remembered as something that happened to me. The "*as if* it wasn't me" is important because it links the *extraordinary* to myself. 'The not myself' is somehow recognised 'as myself'. This describes a dialectic of self-identity and self-alienation that not only makes it difficult for the person him or herself to grasp the sense of this illness, but also makes it difficult to communicate the experienced self-perception to others.

There are clearly difficulties regarding understanding psychosis. First, there is the problem of expressing experiences that are at the limit or transcend possible description. Second, there is the expression of experiences, sensation, and ideas that we most likely do not have in common. The question is, however, whether these are necessary conditions for understanding.

Narratives indicate both the possibility and thus the limit of understanding. If we assume that psychosis makes conspicuous the reality that we cannot see what's going on 'inside' the other person, then we may argue that the examples of psychosis only make a general point about understanding the obvious, viz. that we cannot see what is going on in the other and consequently cannot base understanding on that. It is possible to recognise how we interact to what the patient says despite the obvious problems relating to the expressions of psychosis. The expressions of the patient make a difference, but this is not necessarily the case. Even though we 'think' we understand the other, this might not be the case. When understanding breaks down, we can see it as a form of interaction between at least two persons. Suddenly it may be apparent that we use words differently and that we perceive the same 'facts' differently. The 'breakdown' is therefore potentially an event of clarification that can bring a new aspect into the conversation. The experience of breakdown in communication may represent an act of understanding.

3.2. Identity, self-perception and inner experience

One source of confusion is the fact that different concepts of identity are applied. The first refers to properties, qualities, and other descriptions of an individual (qualitative identity). The second refers to individuality as such, which implies that every person is considered as unique (Numerical identity). A question that baffled philosophers through the 20th century is how outer expressions actually stand in relation to the experience of a person as a unique individual. What has been said about inner states and outer expressions offers a new perspective on this problem.

Self-perception cannot be seen apart from biographical facts, and yet, biographical facts do not delimit self-perception. ‘Who am I?’ simply does not find sufficient room within descriptions of biographical facts such as age, height, weight, kinship, etc. Although these characterisations are essential in certain situations, limiting self-descriptions to them would result in extremely superficial descriptions. Characteristics and self-perception may sometimes be held with firmness even though they could diverge or even appear as strange from the viewpoint of others. Self-perception means that the subject who understands also has become the *object* for that understanding. The narrator is also the main character in the story, which results in a creative act that will be a part of the self-perception. Fiction will be a possible element of any self-description because of the creative act of self-understanding. The need for transcending the facts is not unique to delusions.

For instance, one of the patients commented that I looked like the typical student. Another confirmed with a smile that I looked like a philosopher. They referred to my appearance. I have never thought of my black jeans and shirt in this way, I really do not put that much consideration into clothing, but I can see what they meant. The surprise was rather to be described as part of a group, as something typical. It does not mean that I think they are wrong, but it opposes my self-perception of being an individual. The description of the typical looses the aspect of uniqueness.

On the other hand, both of the two patients that called this to my attention put a great deal of consideration into their appearance. The first minded carefully how she dressed, and it made her stand out from the mass. Another female patient also put a great deal of consideration into her appearance, though her style was completely different. Some of the jewellery was connected to symbols of religion and power. They were worn deliberately as symbols, but also because they accentuated important aspects of whom she was.

Two other patients wore clothing that occasionally could be both dirty and worn. This concerned the staff, partly for hygienic reasons and partly because it could mean problems in integrating outside the unit. Nonetheless, the staff considered interference with these outwardly trivial affairs as potentially interference with their integrity. They therefore attempted to ignore most of the eccentric elements and focus on hygiene.

On the other hand, the way you dress, even though it really is harmless, could still create serious problems in fitting into the society. For instance, people normally do not use two sets of spectacles at the same time, one on top of the other. It might also be pleasant to wear a jogging suit and T-shirt, even though it might be dirty and worn. One patient showed me his wardrobe, which at the time consisted of a couple of shirts, T-shirts, and sweatpants. He explained that sometimes he did not have a clean T-shirt, and then he used the least dirty one. "But then they [the staff] starts to complain." He said this with a smile: "And I have to do laundry".

However, the inclination to view the *expressions* as secondary rests on an idea of an inner core or essence that constitutes what we may call personality or identity. If we imagine the inner states as an independent entity or the sum of all personal properties, it may explain why we see the continuity in the descriptions of a person. In that case, what kind of 'core' is this? Can we imagine the inner states apart from its expressions?

Then again, trimming hair and beard may in fact change the appearance in such a manner that one is perceived differently altogether. It is apparent that outer and *trivial* factors may influence the perception others have of *who* we are. Identity thus seems transient, passing, and elusive. How is it possible to emphasise stability and continuity in descriptions of identity when even a simple haircut or change of clothes will change the perception of who we are? The outer expressions have therefore a key role, not only because we have access to them, but mainly because they present an access to the other person.

We are willing not only to speak of change based on outer expressions, but also to admit that this change may be significant. This does not mean that we have removed the concept of personality or 'inner qualities'. However, it does mean that it is problematic to uphold these concepts independently of the outer expressions or as the basis for them. Reckoning 'outer' expressions as superficial assumes a misunderstanding of what ‘inner’ or a ‘deeper’ understanding would imply. On the other hand, keeping the aspects together opens a creative setting for the narratives as an access to the other.

4. UNDERSTANDING MADE IMPOSSIBLE

Patients often claim that others cannot understand them since others have not had the same experiences; this is an idea that they share with mainstream psychiatry. It is furthermore interesting to notice how understanding is used to describe settings and conversations in which understanding has become a problem. Is it possible to describe the problems of the patients from a first hand perspective in order to examine the patient's perception of the illness and how people deal with them? The following chapters will deal with different ways of using understanding to examine how understanding may become impossible.

4.1. Anxiety and hope for deliverance

A patient approached me on the first day of the fieldwork and straightforwardly expressed a wish to talk about a problem he had with anxiety. He had been told beforehand that I have both a theological and philosophical background. He came with a definite concern: "It is bad", he told me, "and it hurts right here." He indicated a small area on the left side of his stomach. I asked him what it was, and he answered by raising a discussion over several existential concerns in order to explain this pain in the stomach. He started by asking: "Do you believe that God will forgive murderers and paedophiles?" I was troubled by his question. I did not know anything about him, and I sensed that this question was based more in personal experiences than a solely theoretical interest. I also suspected that he was likely to test me. My answer was evasive. He did return to this question several times during our conversations. Murder and paedophilia were important as *examples* of the *worst* things one person could do towards another.

He asked a chaplain the same question. The priest assured him that God would forgive anything. The patient admitted that he found the solution of the chaplain too easy, even though he knew that the chaplain simply recapitulated the Lutheran dogma of reconciliation. The patient found the answer unsatisfactory. He explained: "Murder and Paedophilia are sins that literally have destroyed human lives. How can God overlook that?" The question was not *if* but *how* God could forgive. The question was not rhetorically meant, but stood rather as an exemplification of an innate and possible contradiction within the dogma as such: How can God forgive on behalf of others? Implicitly, this might be the case, and yet, how can God let the victim be destroyed and allow the offender to go free simply because he is remorseful? The consequence does not stand in relation to the misdeed.

Another aspect was how divine forgiveness is possible at all, and thus whether there was any hope for him. The question was related to other concerns, like what would happen if one had committed a sin towards somebody and one did not seek forgiveness from that person while he or she was still alive. Is it possible to ask forgiveness on behalf of others? Is it too late to do that when the person has died? He usually started with one of these questions and continued with far more personal and direct narratives afterwards. The questions could then reappear along the way, which clarified the importance of the questions. The narratives established a clear but compound context in which he tried to come to terms with his own life.

The story that evolved actually consisted of 5-6 interwoven stories. The same stories were told from meeting to meeting. The different stories mutually illustrated and explained the elements of the others; in addition, they explained the facts of his life. He did not tell one story first and then another; instead, he presented a principle autobiographical theme and changed from story to story from one moment to the next with no apparent reason. The stories always came simultaneously and they overlapped each other. Instead of viewing them as one uniform or several separate stories, they appeared more like a 'bundle'.

It was very hard to follow during the conversation and even more difficult to recapitulate the content in the field journal. It required a great deal of concentration to listen to what he said. The stories were interwoven and he would leap from one story to another to explain what he meant, or simply follow a sudden association. The subject could therefore change for no apparent reason. At one time, he excused himself and told me that this was due to his illness and problems of maintaining concentration. Yet, I could see a larger picture of a life narrative take form.

He started by presenting his problem, which was that he suspected that God had condemned him. He was not certain although he feared that God had reasons to condemn him. It had nothing to do with murderers or paedophiles, but it was about destruction of lives. He had asked almost all the clergy in the city the same question about the murderers and paedophiles. The question took the issue of reconciliation to its extreme. He could not settle with the answer they gave because it seemed too easy, as if they took the problem too lightly and overlooked something essential, or did not understand the kind of damage it involved.

His system of belief did not contain anything bizarre. He did not hear God's voice, nor did he speak to God. He did not think that *he* was God. His problem was rather that he had reason to believe that God had left him and would not forgive him because *he* was an evil person. In a way, he found this suspicion confirmed by his life and the fact that he did not achieve even his most moderate goals. He was therefore stuck with a negative self-evaluation. Moreover, if there was no forgiveness at hand, then the sin would cling to him for the rest of his life, and he would be condemned.

We could try to overlook *our own* world-view and attitudes towards religion, and try to see the world from his point of view: Imagine that *you* are convinced that *God* has condemned *you*, and that if you *die*, or the world comes to its end, you will most certainly go to *Hell*. From this perspective, it should not be too difficult to understand that he wakes up at night and is afraid of dying.

However, he also reported confrontations and rejections. First, there were those he called 'the pagans' whom he totally wrote off as interlocutors. Second, he complained about those who changed the topic from what he saw as the real issue. On one hand, it should not be problematic to see the world from his perspective; on the other hand, it seems impossible not to argue one's own view against him. It is not difficult to understand either the clergy who corrected his view of grace, or the staff who asked about his medications.

When we first talked about these things, we had just entered the new millennium. I therefore asked him what he did on New Years Eve, knowing that some religious groups connected the second coming of Christ with this event. He said that he spent most of the time being terrified, waiting for 'Ragnarok'.[14] He said that he felt sure that it would be too late for him to settle important issues and seek forgiveness if it happened there and then. He would be eternally condemned. "It was a massive attack of anxiety", he concluded.

When asked whether he had told anyone this, he affirmed that he had, but complained that when he brought this up they just said, 'Yes and Hmm!' and immediately started asking about the medications. He immediately added that he received "... one drug against the psychosis and others against anxiety". He experienced the effects of the medications as problematic because "they only make me forget the problem, and then I forget to seek forgiveness and then nothing is solved" (Patient).

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[14] Traditional Norwegian phrase that means "The end of the world" or "twilight of the gods".

When I left, he asked one favour of me: “Could you please say the blessing, and make the sign of the cross on my head”. This surprised me. I was not sure what to do about it. I was sceptical, because it meant that I not only had to discuss religion on his premises, but also participate. This could come into conflict with the role of researcher, but it also challenged what I felt as decent or acceptable. He asked it as a favour that he would appreciate.

The reason I complied was the choice of participating on the terms of the informant and not my terms. Participation constitutes another type of experience that includes a source of information that can remain undisclosed in other types of research. It isn’t unproblematic, however, I saw it as doing him a favour, although I felt a bit uncomfortable. I was not accustomed to this, but knew one blessing by heart and recited that. It came out wrong, and he asked whether it was a new one. I said that I mixed up the words, and he asked whether I could say it again just in case.

The next week he said that he felt the effect of this blessing for four days, which he deemed better than ‘Valium’. Consequently, he was interested in whether I knew how long an ordinary blessing could work. I honestly had to say that I had never thought of that. I suggested eternally, but then he asked why priests repeat the blessing every Sunday service. The line of questions was quite peculiar. Although magic was never mentioned, the questions almost implied the possibility of a magical explanation, although he most likely was searching for a way to rule out magic from the experience.

One could easily confuse his question with naïveté; conversely, it is rather ‘hyper-rational’. He asked simple questions and by them touched on the absence of logic in customary ways of thinking and in theological questions. It represents a pensive question: “Shouldn’t we take our opinions seriously?” In a sense, he took the clergy and their preaching more seriously than they most likely do themselves. He indicated a manner of seriousness most people lack, or even regard as suspect, as if it has to demand a type of fundamentalism and intolerance of them. However, the only thing he actually implied was honesty towards one’s own values and opinions. This is hardly anything that one can *dispute*.

The question of the blessing invites to a dialogue in which he tests this concept and its possible inconsistency, with the possibility of rejecting or reorganising some part of the concept. I am not sure how he concluded, however, I am almost certain that he did not reject the concepts of faith as a whole.

The dialogue also illustrates how participation inevitably influenced the situation, luckily in a constructive direction this time. However, this situation in itself illustrates a critical aspect of the interaction. The intention was to recapitulate his point of view on his premises, and even though I had to be conscious of my own resistance towards the position of the other, it was important to overcome that and try to recapitulate it on the premises of the other. The position of research also endorsed no responsibility towards the treatment or his well-being. Of course, when he asked favours of me that staff normally would help him with (for example: I changed a light bulb once) I complied without any hesitation. The freedom meant that I did not *have to* take a standpoint towards the reality in his stories nor confront him with it. Instead, I could ask him to elaborate or explain. On the other hand, it is interesting to notice how different people with whom he had spoken tended to fall back on their initial positions either as Lutheran pastor or psychiatrist. In one respect, it is called for, in another, it was seen as problematic or as if they did not comprehend what he was trying to communicate.

What was it that made it almost impossible to assume the premises of his narratives? Despite different views on ethics and religious belief, this was not a central issue. It was rather a clear perception that his opinion had consequences for him and threatened to ruin him. This self-destructive aspect became difficult to assume. It meant that I constantly thought to myself: "you *shouldn't* think that!" There was a constant wish to correct him or oppose his thoughts and attitudes to life. I tried not to do that, but he often asked me directly. Then I answered him honestly that I thought he was too hard on himself. I also added something about the reason why I thought this, which perhaps suggests that I after all have some understanding of the problems.

4.2. Doing the things I do not want to do

An informant talked about some regrets of the past. The informant said: "I was very immature and insecure as a child." Some people in the environment took advantage of this, and the informant saw them as "bad company". On the other hand, they gave a sense of belonging throughout some of the more difficult youth years. Today, the petty crime that was committed stood out as the price that was paid to receive a sense of belonging; however, when the informant was caught shoplifting, the friends disappeared. They saved their own skins while the informant spent hours in custody alone. There were other incidents, too:

> I heard recently that NN (referring to the leader of this group) died. Do you think it is wrong of me to feel sorry for him? He did some bad things, also against me, but I see him as an unfortunate and tragic person. The things he did to me are bygone and partially my responsibility. (Field journal)

This came as a surprise to me not only because of that which was considered to be bygone by the informant, but also the responsibility that was assumed for events that were out of the informant's control. The natural reaction was to argue against the informant: It is not right to take responsibility for actions one has been exposed to by others.

It illuminates how we may agree on the biographical facts. Nothing is unlikely to have happened or impossible in what he tells, and yet we may evaluate the 'facts' in various manners. In this case, it meant that although there were things to regret, the negative evaluation that it received seemed exaggerated. I can understand that a victim under certain circumstances may feel responsibility for being exposed to an offence, but this self-blame is an impossible position for me to endorse. The approach to what was said has to start by both recognising and rejecting the blame. It was not difficult to see what it meant, but it was impossible to accept its premises. When listening to the story, all I could think was: "You cannot say this!" How can I listen when my initial response was to correct what was said?

Lack of understanding, in the sense that we do not see what the other means, would be an instance that calls for clarification. There can be problems of poor articulation, confusion with regard to understanding of concepts, or (incoherent) arguments. This does not necessarily mean that the belief is deluded or even uncommon.[15]

It was difficult to continue on the terms in which the story was being told. On the other hand, the stories revealed a contrast between the opinions, values, and perceptions of the listener as opposed to the patient. What makes us withdraw from each other? Is it impossible to find a common ground on which we can talk about certain matters? Is it possible to assume the premises of the patient without surrendering to his or her world picture?

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[15] There was a very interesting discussion around the concept nothingness at the unit. One patient, who was inspired by Buddhist theology, talked a lot about nothingness. Her use of the concept nothingness thus diverges from the western use of the concept. It can be clarified and she explained it to me; however, it demands another metaphysical approach. The difference is easily overlooked. Heidegger made a similar mistake regarding nothingness in a dialogue with a Japanese (Heidegger, 1971).

4.3. Lost concepts and secondary sense

Cora Diamond describes in *"Losing your concepts"*, how the concepts of religious and ethical language have lost their meaning. This problem of grammar is more fundamental than just rejecting the content of religious and ethical expressions. Losing the concepts implies that we lack a language in which we can account for ethics (Diamond, 1988). She argues in *The Realistic Spirit* that secondary sense from Wittgenstein represents an account for the type of grammar or a way of speaking that is necessary to express certain aspects of life. She says:

> I want to suggest that what Wittgenstein called the use of certain expressions in an absolute sense in ethical and religious discourse has certain logical resemblances to what he later called the use of an expression in a secondary sense. (Diamond, 1991:225)

We understand and relate to different expressions. This may represent acts of understanding, even if it is difficult to paraphrase or articulate *why* and *what* we in fact have understood. The explanation has therefore partially been left out; not that any explanation will do, but rather that accounting for it would demand more than we can possibly do with language. It would end in a *misuse of words*.

The potential in Diamond's comparison of *Secondary Sense* with *ethical discourse* is not to offer an explanation as to *how* we understand. It is rather an explanation as to *why* certain expressions can be left unaccounted for. She claims:

- In ethics expressions which have a straightforward fact-stating sense are used in another, 'absolute' sense.
- These ethical uses are connected with experiences which cannot be described without misuse of language
- These uses appear to be similes, but what they say cannot be paraphrased using only words in their primary sense.

Why cannot secondary sense be constructed as similes or metaphors? Wittgenstein admits the similarity, however, he denies this possibility because similes utilise the primary use,[16] and viz. the placing together of words and constructing new expressions offer meaning. Secondary sense represents a shift in what is meant. This shift will not necessarily be explained by

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[16] I use primary and secondary use as abbreviation to "use in a secondary/primary sense" (Diamond, 1991:227; Wittgenstein, 1958b:§282)

synonyms. Secondary uses of language do not involve similes. With a simile it is possible to explain what you are using the words to mean without going beyond 'significant language'. "To understand is *not* to be able to give a paraphrase in words used in their primary sense; nor is it to see what is said as *merely* the expression of an emotion" (Diamond, 1991:236).

Wittgenstein gives an account for ethical statements in *Lectures and Conversations* in which he claims that he would have understood it entirely if someone said to him: "We might see one another after death!" He rejects that this simply states a certain attitude, and it may not be the same as saying anything else. Why should you be able to substitute anything else? It says what it says (cf. Wittgenstein, 1967). Diamond's effort to rule out metaphors aims at taking secondary sense as a fundamental use of language, and not to derive secondary sense from primary sense and thus making secondary sense superfluous.

Cavell's explanation is that concepts are connected to our life world (Cavell, 2000). Usage cannot be detached from life world, nor can the secondary use of words. Secondary sense is not part of the actual definition of the concept, but it is still a part of what we think or associate with the word. For instance, a pumpkin is a large, round, orange vegetable with a thick skin. These words constitute its definition in the dictionary. The little man called 'Jack' is not. I suspect that Cavell does not *really* expect the little man called Jack to appear (although I cannot tell). Still this little fellow is part of what 'pumpkin' might bring to mind to an American. So was the thought of pumps and Mr Popkin. He later abandoned these ideas as connected to pumpkins. The associations of a child are freer. He nonetheless sees the phonetic connection and he remembers the connection as something he once believed.

Secondary sense opens a context belonging to the concept that transcends the concept itself. The meaning is founded in common usage or a shared language. The secondary sense can exhibit both public and private features, but it is not private in an exclusive manner as would be the case if it were part of a *private* language. Even though I never knew Mr Pupkin, I still see what Cavell means when pointing to his connection to pumpkins. Moreover, if I for some reason did not understand, I am sure Mr Cavell could explain it to me. The content of secondary sense is outside control, yet it is understandable. The associations may also be more free, dissimilar, and bizarre than the associations Cavell has described.

Secondary sense becomes relevant when a word is placed in a new context. This is particularly important concerning psychotic events. I got the impression that these experiences were so private that the patients were reluctant to talk about them. Part of the reluctance may be seen in the context of the significance these kinds of stories have to implicate compulsory treatment and medications. It was only after we became acquainted that *some* of the patients told me a little about this. The descriptions sometimes lacked suitable words. The description of visual and auditory experiences could be figurative, as when you try to describe something you have seen or heard. Some ordinary words had to be explained. An informant was speaking about his illness (schizophrenia) and early problems.

> P: I love my mother very much.
>
> I: Is it because she has always been there?
>
> P: What do you mean?
>
> I: That she has stood up for you and supported you when things have been difficult.
>
> P: She was never there when I needed her. Sometimes I had to beg for food at a local bakery. It was because of this that I started to hang out with the criminal milieu. (...) When my father became violent, I tried to withdraw, and didn't dare to go home sometimes for several days. I hated him so much, especially when he hit my mother. I looked forward to grow up and be strong enough to have her revenged; I wanted to kick his arse.
>
> I: Did you ever?
>
> P: No! Today I see that he is an unfortunate man like me. I cannot hate him, I feel sorry for him, and often pray that God must not condemn him.

When a patient tried to tell me what his mother meant to him, it seemed to involve other stories illuminating the concept, and involving narratives and characterisations that stand far away from my perception of 'mother', but that were defining for his perception of mother. The primary sense of the concept is not in question. The patient used the concept neither randomly nor by habit. Instead, it opens an aspect of the relationship (love/hate) that transcends my prior knowledge of the patient. It is also difficult to see how one could be so kind and generous in these contexts. It is rooted in a life world very different from my own; and even though the difference in usage is present, it seems unproblematic to immediately grasp what he is saying. The difference in usage and life world brings in a creative aspect of language when we manage to exhibit these differences.

It is important to notice a difference between Diamond and Cavell. Cavell looks at poetry with regard to secondary sense, and Diamond compares it to ethics and religious propositions.

Cavell thus pronounces the creative aspect of language and Cora Diamond emphasises understanding as an immediate relation to the expressions. It is also important to notice that the secondary *sense* in Cavell is not the associations or play on words as such. Private and even peculiar associations may communicate. The expression may therefore bring something new into the conversation and release a new aspect as something we share. We see what the other means. It does not explain how secondary sense makes us understand.

Diamond emphasise the irreducible character of these expressions. She is interested in how secondary sense may be used in order to give one's feelings, or experiences meaningful expressions. She refers to an example given by Anscombe who speaks of referring to internal descriptions of sensation. "The sensation of flying" suggests the sensation you would get if you were flying.

> It uses therefore words taken from elsewhere; it is as it were a metaphor – only *that* this metaphor strikes one as part of the experience it expresses (Diamond, 1991:232)

Only those who can speak of flying in ordinary circumstances are able to have this experience, yet there is a shift in meaning when it is taken out of these ordinary circumstances. The expression is also expressive apart from the actual experience of flying, or would I claim that anyone that has not flown has no idea of what Anscombe and Diamond mean? The sense is immediately understood, which is as it must be in order to be a good description.

Secondary sense is an approach towards the problems represented by expressing and understanding psychosis. Secondary sense establishes a context, which allows us to see expressions of psychotic experiences not in opposition to ordinary speech but in connection to it. The creative aspect of secondary sense is that words from other areas may be used to express experiences. The expressions reveal at least glimpses of what it is like. Secondary sense allows the expressions to account for nothing but themselves. It cannot be rephrased, nor is it necessary to interpret it as representing states of minds, sensations, or feelings.

We could assume that the inner experiences accompany the expressions. The potential is to perceive the expressions *as* part of the experience they express and not necessarily as descriptions or explanations of something else. Speech itself establishes this relationship of experience and expression. The immediacy of understanding affirms that this is not a private language.

5. Expressing Oneself and Understanding Others

To be understood is closely related to being able to express ourselves in a way that others are able to grasp what we mean. How we express ourselves depends on what we try to understand and what we mean by 'understanding'. There are however limits to understanding. This is crucial to schizophrenia because we do not share certain experiences that characterise the life situation for the patients. There are certain places we cannot go and things that cannot be said or demonstrated. However, this limit is not unique to schizophrenia. Schizophrenia does however raise several interesting questions. How may a foreign life world be revealed to an outsider's perspective? How far can we understand the life world of the other person? Another way of putting this has to do with establishing a common language in which we can deal with these issues.

5.1. Understanding and disparity

The question 'do you understand this?' is meaningful to ask under different circumstances. What we mean will leave no doubt in most situations. There are situations in which particular problems of understanding occur because what we *mean* by understanding may take us in *different directions*. We use the concept 'understand' in different ways. What it means to understand another person may seem contradictory because different ways of using understand are applied in the same case. Lars Hertzberg argues in *'The limits of understanding'* that the main difficulty is not different usage of the term 'to understand', but that we take the verbal-intellectual form for understanding as a *paradigm* of understanding, and thus regard the other uses as more or less peripheral or metaphorical (Hertzberg, 2003a).

These different kinds of usage illustrate how we can mean different things when saying that we understand. It is one thing to know the name of the capital of Bolivia. It means that one at least is able to give the correct answer when asked. It is another thing when we ask patients whether they understand their illness. For instance, an anorectic patient may very well state the correct answers to all the known facts of her illness and yet starve herself to death. Will we then say that she has understood? In one respect, she does, but in another, she does not. The possible inconsistency compels us to think that we are talking about different concepts. One could also assume that the different uses of 'understanding' become ambiguous because the different usage is not precisely articulated. Hertzberg suggests a third possibility

> In saying that I find someone's behaviour incomprehensible, what I am saying, roughly, is that an appropriate attitude towards the behaviour is impossible to find (Hertzberg, 2003a).

He argues that the variations between the different uses of understand do not represent a problem. The dissimilarity between the various usages of understanding is helpful in comprehending why understanding becomes problematic despite what initially seems to be easily accessible patient narratives. The problems of understanding the patients in the preceding chapter, *'Understanding Made Impossible'*, have nothing to do with intelligence, insufficient explanations, or inadequate expressions. It also has little to do with insufficient references to the world, differences in background, or horizons of experience. It is therefore decisive to explore what the problem is. *If the patients really follow a road that we for different reasons cannot follow, why is it impossible to do that?* Delimiting the question to a question of rationality or ability to explain seems inadequate when judged against the experiences of speaking with patients.

In one instance, after one particular conversation, I could identify six major issues that were impossible to leave uncontradicted. This does not mean that one actually does challenge the dialogue partner and contradict him or her, but it was sometimes difficult to know what a serious or proper attitude would be. Simply continuing the conversation could easily fall back into playing along with the person, or just answering without really taking what is said and done seriously.

Patients made complaints that people did not listen to them and that they instead changed topics. This could be an expression of the patients' first hand experience of other's reluctance to follow on their premises. For instance, it is not difficult to comprehend why staff changed topics to talk about medications, or why the pastor informed about the dogma of reconciliation. What is it that hinders our assuming the premises of the patients? It has to be something more than just disagreement.

There are aspects of life that can be regarded as impossible to account for or explain completely. However, in other cases it is not quite certain what understanding would imply or what we mean when we claim that an expression is incomprehensible. Lars Hertzberg investigates an interesting aspect of understanding that is relevant, although he turns towards the problem of evil to illustrate reluctance. He asks what do I mean if I say that *I cannot understand a sniper that is able to shoot at playing children in Sarajevo.* It represents an action that hardly is done by mistake. Depending on the distance and the strength of the telescopic sight, you can actually see the eyes, colour of hair, and clothes of your *target*. Moreover, a sniper will most likely aim at the upper body, which is the easiest point to hit and kill. It is a deliberate and well-calculated action. The sight should be corrected for wind and your own location. For instance, sitting high in building needs adjustments a few clicks down on the sight. You must compensate for movement and pull the trigger. Almost anybody with a minimum of guidance and practice will be able to hit a *target* as large as a *child*. It is not difficult to see what is going on or how it is done. What is it that we do not understand?

One sense of understanding is the ability to do or to repeat a task. If I say that I understand the principles of algebra, you would expect me to be able to apply these principles on actual problems and solve them. If in an exam, I did not use the principles correctly, I would fail because I clearly have not understood enough algebra. Wittgenstein claims furthermore that the grammar of the word "knows" is closely related to "can" and "is able to", and "understands" (Wittgenstein, 1958b§150).

I can understand the sniper in one respect as long as understanding is seen as the question of the technical ability to do what he does. Given the right weapon and training, it is not difficult to understand how he can hit a child even on a range of more than 200 meters. However, if the 'ability to do' the same as he did were (contrary to fact) solely a technical question, then 'I do not understand' will not apply. It may apply better as a comment on skeet shooting at the Olympics: "I cannot understand how he is able to hit 25 targets out of 25. They are so small and they move so fast."

Why is it 'unnatural' or even disgusting to compare shooting at children with skeet shooting? It is not legitimate even to speak of children in terms of being a target. The unwillingness to speak in such a manner illustrates that understanding the sniper is different. I may in fact be able to perform the shot or at least see how it is done. I might even be a better sharpshooter, without understanding the person that actually shoots a playing child. It is not a technical question of how to shoot.

Why don't I understand? Is it impossible to know what he is thinking? It would be relevant to learn some history and ethnography to understand the action. However, is it really the case that given the right circumstances, everybody would be able to perform such actions? Thomas J. Scheff argues in *Bloody revenge - Emotions, Nationalism, and war* that the hostility of individuals and groups will be connected to and is in fact natural reactions to prior humiliations, defeats, and losses as both individual and group. Scheff argues that rage and frustration is a natural, psychological response to both pain and humiliation. He describes how these elements of emotional responses have influenced both individuals and nations in previous conflicts and how they can intimate an understanding of events that lead to war (cf, Scheff, 1994). It is to be expected that corresponding elements will also be relevant in Sarajevo. A thorough examination of psychological, ethnographic, and sociological factors could establish a clear image of how the action of the sniper is not only understandable, but it could also be possible to see things from his perspective. The sniper could perhaps inform us of the loss of friends and family. This could explain the desire to inflict real pain on the enemy. It might be possible for us to see why he wants to inflict pain on the enemy. Besides, what could inflict more pain than the loss of a child! What is it that we do not understand?

Perhaps we could understand him if he really shared his thoughts and feelings with us. I could perhaps reach a point where I could claim: "Now I see what you mean", suggesting that I knew his motivation and intentions. Given these premises, his action no longer will stand as an enigma. Yet, this is now moving along a road that I am hardly able to follow. Consequently:

> My not understanding the snipers is not like having failed at a task. I do not consider this to be a failure on my part, the failure, rather, is on the part of the snipers. Again, it is clearly not a matter of skills, knowledge or intelligence. (...) Obviously, too, there is no kind of activity that could bring us closer to an understanding. Nor, furthermore, does our inability to understand entail that there is some judgment we are unable to make or some action we are unable to perform, which we could have made or performed if only we had understood the matter in question (Hertzberg, 1994).

"I cannot understand what you have done!" is a demand for an explanation, which I do not expect can be given since it is not clear what understanding *this would be,* or whether any explanation could answer what is at stake. This does not suggest that we do not see what the sniper means, neither that we are unwilling to look at the subject from his point of view, nor that he is unable to explain all this to us. It could be possible to know exactly what he means without any possibility to tolerate it. Hence, the sniper could say or do nothing that would clarify this act or make it a sensible thing to do.

There is a difference in understanding what it is said and endorsing it. Both aspects play a role in the use of 'to understand'. To illustrate the difference, Hertzberg adds a remark about the cliché phrase about the husband who complaints that his wife does not understand him. Hertzberg suggests that this does not necessarily imply that she does not see what he means, or that it is impossible for him to clarify his position or make her understand his motivation. It could also be the case that she does understand him perfectly well, only that she will not accept it.

One could object to both the discussion and the examples, and say that this is actually a discussion of the concept 'to accept' rather than 'to understand'. Moreover, the problems in relating to evil on the one hand and delusions on the other hand, seek an explanation of the inability to accept that which is said. However, as long as we actually use the phrase "understand" to speak of the relation to the patient narratives, understanding must either be explained or explained away. One approach would be to ask which concept one would prefer to use as a clarification for the withdrawal from the position of the other. In the case of the sniper, we do of course not accept his reasons for acting as he did, however, lacking understanding for his actions says more than that, or doesn't it?

Hertzberg's argument opens for ambivalence within the various usages of understanding that has implications for possible interaction. "I see what you mean, but I do not understand you"; Not understanding implies that I am isolated from the other in a profound manner. The issue of the discourse cannot be shared. Understanding the sniper is made impossible even when we saw the entire line of thought that lead to his actions. *Not understanding* is then also an ethical statement that isolates me from being together with the other. The failure of understanding lies within the relation to the sniper. We distance ourselves from him; we do not *want* and *cannot* share a common ground of understanding. We have reached the point where further conversation is impossible because these grounds do not meet; furthermore, they *cannot* meet without *changing me into someone else*. The example of the sniper depends on a position regarding language as co-existence or interaction. The rejection of the possibility of understanding the sniper articulates the impossibility for a shared ground of understanding.

The task of understanding 'the sniper' differs from that of understanding 'the psychotic patient'. First, understanding the sniper is impossible even though we may have little problem comprehending what the sniper says. The stories of the patients on the other hand, offer an understanding, although it may be an open question as to *how* we understand them or how things add up. Second, we have good grounds for *not* sharing the sniper's reasons for action, but this may not be the case with the psychotic patient. Third, the breakdown of understanding lies on part of the sniper. When it comes to the patient narratives, the question is whether the hindrance lies on our part and what we think of psychosis. If that is the case, then we have to decide how a shared ground of understanding may be established.

5.2. Understanding and isolation

In psychiatric textbooks, the shutting off or isolation of the patients is described as being connected to psychosis and schizophrenia. When Kringlen (1982) speaks of delusions, hallucinations and bizarre behaviour, it is clear that psychosis entails features, sensations, experiences, and opinions that are not shared with the patient. The distance is underlined by using formulations such as 'the patient thinks' '...feels', '...holds as true'. You would not reckon it necessary to say; "the patient *thinks* he is followed", if you do not question the claim. It is not the idea of persecution that is the essence, but rather the fact that a person maintains such a view against common sense or facts.

The same types of descriptions are representative for the standard textbooks and manuals. ICD-10 states that it is typical of a "disturbed, schizophrenic way of thinking" to accentuate and use *peripheral* or *irrelevant* features that normally are suppressed as irrelevant in the situation. Furthermore, talking about *inadequate* or *inappropriate* emotions, *impossible* ideas (like ideas of grandeur, or of religious and political identity), or sustained *exaggerated* ideas all imply the writer's signals that these ideas do not correspond to reality. It indicates that we are brought into a situation in which it is impossible to assume the premises of the deluded patient.

Lauren Slater (1997) describes her experiences as she first entered psychiatry as a doctor. She explains how the patient narratives influenced her. One patient told her about his wife and children living in Birmingham; however, when she checked the information, she learned that this was not the case. She could write off this information and the story as such as not being a part of reality. However, she described how she could recognise *another* aspect of the story that unveiled a likely indication of what the patient meant to say. For example, the patient wished to belong to someone and dreamed of being in a relationship where the care was mutual and where one was irreplaceable. Slater also wanted that for herself, so that the stories gave her glimpses of how wonderful this dream of a family must be for that particular patient. This stood in sharp contrast to the harsh reality that may never grant him the pleasure of family life. It was not difficult for her to understand why he refused to accept the idea that his family did not exist.

She described another event in which the desire to leave the hospital and be free came to expression during group therapy. One patient repeatedly talked about spaceships and aliens. He also claimed that he had 100 wives at Pluto. She had always denied all this as part of the therapy, but she became curious about the narratives and she asked him where this spaceship landed. At this moment, it had landed on his stomach. She asked if the group could be given a ride in this spaceship and he approved. They arranged themselves in a circle where all held a hand on his stomach. He told them what happened when they took off and flew away. Through the narrative that arose, they ascended through the hospital ceiling and saw the city from above, they continued out into space before returning to the hospital. Everything happened through the fantasy and an incredible story told by that patient.

As Slater recapitulates, these incidents gave her glimpses of desires, wishes, and emotions that she did not expect to find in the patients. These aspects of their lives were never talked about. Moreover, it represented feelings, intentions, and dreams that she could recognise and share. Even though the reality of some of the stories may seem bizarre, she found the experience of them as completely rational. She still admits that after the trip in the spaceship, she looked anxiously at the open door hoping nobody had seen them: as if she had done something wrong or unacceptable in allowing the narrative to develop.

Understanding implies that I could *show* you, and you could see what I meant. It implies not only intellectually comprehending that which is said. Slater is more concerned with the manner in which she crosses the limits of indifference, and thus experiences how she can identify with the patients' expressions. She is interested in learning how patients' stories reveal explanatory and expressive aspects. She maintains that such learning is possible despite the fact that the language-games of psychosis are extraordinary. Concepts like delusion and hallucination imply that the objects of patient's minds, or their sensations, do not necessarily exist in a public room. However, rejection of their expressions as something that *cannot* be shared also excludes the possibility of understanding. When staff spoke of the patients, a form of understanding had been discovered. This places the expressions of psychosis in another light; that is, delusions can be very understandable as self-expression almost despite what is actually said. One may not agree with the description of the reality or the evaluation of the surrounding world, and yet there may exist the possibility of shared understanding in which the delusions become very meaningful.

The focus on facts, intellectual abilities, and the ability to clearly state what we mean, present a too narrow use of understanding to illuminate these possibilities. We need a more radical view of language in order to account for these aspects of understanding. Do we actually discuss different concepts, or are the different uses part of the concept 'understand'? This question may be difficult to answer. Different uses indicate that we say different things. On the other hand, by maintaining a unified concept of understanding that endorses various usages, we also say something about why we see different instances in connection with each other.

Is the ambivalence of understanding the result of different usage of the concept? It would not represent a contradiction, but rather a dialectic within the manner in which we actually are willing to use the phrase understanding. Does this also point to a potential and creative aspect of the interaction with patients? The ambivalence signifies an experience of breakdown in which understanding becomes complicated. As discussed in relation to Cavell, the situation of misunderstanding may reveal that understanding may have been absent or a misconception. However, the possibility to acquire a shared language depends on testing our concepts. The adjustment can hardly be imagined apart from the situation of error in which difference of meaning becomes conspicuous.

The advantage in working with psychosis is that it is easily obvious that we do not have identical experiences, and that we cannot assume identity of meaning. We cannot do that in normal circumstances either; however, the psychosis only make a general point clearly visible. For that reason, the narratives of the patients *invites* to either a closer look or silence.

Understanding the patients is thus no easy matter, and it is possible that much of what we may call understanding might go by unnoticed. It is therefore not remarkable that patients express a resignation towards this situation because one realises that one has to live with this. The description of schizophrenia as an illness accounts for the problems the patients experience. Being excluded or withdrawn from the possibility to account for oneself will increase the degree of seriousness of these experiences.

Moreover, there is the question of deception, of both oneself and others. There may be a number of reasons to deceive others. Not all of them are serious at all:

> An evening in November, when I arrived at the rehabilitation unit, an informant told me that he looked forward to hearing me on Christmas Eve. I said that I did not understand. He said that the head nurse had told him that she wanted to ask me to help with some of the programs in the afternoon on Christmas Eve.
>
> My first reaction was to wonder whether this was something that he made up, or that he was deluded. However, he continued in a very convincing manner, which made me wonder why the head nurse hadn't told me about it herself. We had indeed an understanding that I would participate during a meeting at the unit, but I had never heard anything about Christmas. I had plans to go away on holiday, too, how could I get out of this one?

He laughed merrily of me and asked: "Did I fool you?" I was relieved and confirmed that he had me going there for a minute. Although this bluff was the best one he pulled off, he always tried to say or do something one way or another, to make me uncertain or confused. It was his kind of humour. Jokes like this can be amusing, still it could sometimes be hard to know whether he was bluffing, whether he believed it (delusion), simply was mistaken, or whether it really was so. In a way, I had the distinct perception that he played on exactly that insecurity as part of the joke, thus utilising the possibilities of delusion as part of the joking.

The ambivalence is on the one hand that we understand what is being said, but on the other hand that we have problems knowing how it is supposed to be understood, or whether we have understood correctly.

5.3. Establishing a common language

In *Excursus on Wittgenstein's Vision of Language,* Stanley Cavell explains shared language in terms of common life world and the use as *projecting* of words (Cavell, 1979; Cavell, 2000). Projection means that a word can recur in a new context. Language belongs to the life world, but neither the world nor the language is static. Words must allow to be projected into a new area whenever they are used since every situation has something new about it. Words must deal with the openness that consists in every reapplication having something unique about it. This means that words can recur because they can be projected into new contexts.

The alternative is having nothing to say. This silence has little in common with the problems of the 'private language', although Cavell sees analogies to the discussions early in the *Philosophical Investigations*. With no backup in definite rules for adequate projections, all we have to go on is our confirmed ability to speak to each other. New contexts must tolerate, or invite to, projection of words, and words must deal with this openness. A too restricted and rigid concept of rules may dissolve language. We must therefore connect flexibility to concepts.

> If there are no rules or universals which insure an adequate projection, (…) then a new projection may be *made* appropriate by giving relevant explanations of how it is to be taken, *how* the new context is an instance of the old concept (Cavell, 1979:192).

The alternative would be to invent a new concept for every situation and instance we came across, which cannot be said to reflect how words actually are used. The connection between form of life and concept is crucial to Cavell. He describes this aspect by an example:

> Take the day on which, after I said "Kitty" and pointed to a kitty, she repeated the word and pointed to the kitty. What does "repeating the word," mean here? And what did she point to? All I know is (and does she know more?) that she made the sound I made and pointed to what I pointed at. Or rather, I know less (or more) than that. For what is "her making the sound I made"? She produced a sound (imitating me?), which I *accepted, responded to* (with smiles, hugs, words of encouragement, etc.) as *what I had said*. The next time a cat came by, on the prowl or in a picture book, she did it again. A new entry for the Baby Book under "Vocabulary"! (Cavell, 2000:23)

Although mere repetition strengthens the father's confidence that she has understood the word correctly, it does not necessarily mean that she actually understands. This was questioned a couple of days later when she pointed to a fur and said 'kitty'. His initial response was disappointment since it had become questionable whether she had actually understood. His second reaction was happier because …

> She means by "kitty", what I mean by "fur". Or was it what I mean by "soft", or perhaps "nice to stroke"? Or perhaps she didn't mean at all what in my syntax would be recorded as "That is an X". (Cavell, 2000:24)

Cavell sees this as an example of a *misunderstanding*. It occurred because what we call 'kittens' does not yet exist in her world *as kittens*. She has not yet acquired the form of life that contains the concept. Although she was pointing and uttering the right 'sounds', there is no way to know what she was actually pointing at or what she meant. It could even represent an entirely different grammar. He starts to search for meaning. Perhaps the tone of the voice is part of different meanings to the child – or the manner it is expressed? It is difficult to decide exactly what she meant, for instance: "This is like a kitty", or "Look at the funny kitty", or "Aren't soft things nice?" or "See, I remember how pleased you are when I say 'kitty'!"

I agree with Cavell in that it may be impossible to decide this, and even that there may not be a choice between the alternatives. Knowing a word presupposes knowledge of the life form in which it participates. Speaking with children illuminates the difficulties and limitations. We do not know exactly how to speak of certain things simply because the context in which to speak isn't yet there. Cavell continues.

> "When, later she picks up a gas bill and says "Here's a letter", or when, hearing a piece of music we've listened to together many times, she asks "Who's Beethoven?", or when she points to the television coverage of the Democratic National Convention and asks "What are you watching" I may realize we are not ready to walk certain places together. (Cavell, 2000:24)

The actual form of life delimits possible understanding. At the same time, we must be open to change and expansion, otherwise we cannot learn anything or adapt to new situations or cultures. Cavell says that the erroneous use of the word 'kitten' after all shows that his daughter masters language. She is in fact able to project words into new contexts. Moreover, she learns by gathering new experiences about what is meant. Her ability to *project* the word, even though it came out incorrectly, indicates that she knows *how to use words*. Moreover, this projection of the word also tests the concept against the use of her father. She steps into a new area that leads her one step further into a *shared language*, and consequently a *shared form of life*.

The correlation is important: Shared language does not only lead to shared form of life, a shared life form is also necessary for shared language. At some point, we must enter this dialectic of life world and language. Cavell rejects the vision of language that describes it " … as if the child arrives in a strange country and did not understanding the language of the country, that is, as if it already had a language, only not this one" (Cavell, 1979:28; Wittgenstein, 1958b:§32). Learning to use words is not limited to the question of how words take reference.

Cavell describes how his daughter learned something about 'kitty'. The possibility to learn something is embedded in the possibility to project the word into new situations, which also means the ability to project it outside its correct use. Error can then be corrected, which results in the child's gradually is being introduced into a common life world. Gradually, she acquires a shared language, and that introduces her into the world of her father. It is however interesting to ask whether he as father, also learned something from the situation.

Learning a language is simultaneously learning and acquiring a shared life world. This is not a unilateral process. It is not just the child learning something; it also reveals an opportunity to view the world from the standpoint of the other. The question is how we reach the point where it becomes obvious that we perceive the same circumstances and words (slightly) differently.

5.4. Language transcending the particulars

It is easier to accept that we have subjective perception of concepts and the world than to assume that the meaning of words is not fixed. According to Cavell, philosophers usually have described concepts in terms of universality. The problem of universals has been perceived as a problem of assigning words to particulars. Wittgenstein turns his attention away from the traditional approach and turns towards how we learn and use words in certain contexts. This means, according to Cavell, that Wittgenstein reverses the traditional discussion of the generality of language. He takes a particular context as starting-point to how words mean, and thus the problem is not how general concepts assign to particular things, but how concepts can be general at all. Could we imagine a language if words did not transcend the particularity of specific situations?

Cavell maintains that particular instances are necessary to understand the universal. In teaching a child a simple word like pumpkin, we could point to a pumpkin and say "Pumpkin". This initially teaches the child both what a pumpkin *is* and what the word 'pumpkin' *means (Cavell, 1969:21).* It led him to investigate how much a matter of knowing what a thing *is,* is a matter of what it is called. He later took this further:

> Nor, in saying "Pumpkin" to the child, are we telling the child what a pumpkin is, i.e. the child does not then know what a pumpkin is. For "to know what a pumpkin is" is to know, e.g. that it is a kind of fruit; that it is used to make pies; that it has many forms and sizes and colours; that this one is misshapen and old; that inside every tame pumpkin there is a wild man named Jack, screaming to get out (Cavell, 2000:23).

To be able to tell someone what 'Pumpkin' means, the other has to be able to *ask* for that (or comparable) information. You cannot tell a child what a word means unless the child has learned what 'asking for meaning' is. In the case of a child still coming to a mastery of its language, *neither* what we teach them about the meaning of a word, *nor* the word we use to name a specific object may be fully true. To say that the child learns by naming objects, like a kitten, one presupposes that the child is a small adult, and that he/she already has a language. Instead, he suggests that learning a language is growing into a form of life.

> When you say "I'll take you tomorrow, I promise", the child begins to learn what temporal durations are, and what *trust* is, and what you do will show what trust is worth. When you say, "Put on your sweater", the child learns what commands are and what *authority* is, and if giving orders is something that creates anxiety for you, then authorities are anxious, authority itself is uncertain. (Cavell, 2000:27)

A single word may be connected to a variety of meanings and usages, and a variety of situations in life. The associations may be relatively free, and yet relevant. Learning a language is not merely learning to pronounce sounds and learn their grammatical order, but it is also to learn a 'form of life' that make the sounds do what they do, viz. expressing a wish, pointing, indicating affection or aversion, or making a choice. If the child does not follow us, knowing when we have and have not accepted the identity of his or her words, then the child cannot learn and will not grow into our world.

The generality of language resides in the use of words, although learning them and applying them is always linked to a particular situation. Projecting words is learned or used in anticipation that words can be used again in a *similar* situation. This identity is a property of the language, and lies neither in the situation, nor in the pointing; hence projecting explains an immanent transcendence in language. It is immanent because it starts in and cannot evade the particularity; it is transcendent because it establishes an identity to every kitten or pumpkin as 'kittens' or 'pumpkins'.

The perspective of language explains the "Dialectic of the trivial" as a creative and necessary aspect of rehabilitation. On the one hand, sharing life world means that there is something to talk about. On the other hand, there is ambiguity, which means that understanding is questioned. How does such breakdown of understanding arise? When may it become obvious to us that we cannot assume identity of meaning?

5.5. The importance of not understanding

Cavell describes what we could consider an obvious misunderstanding in the conversation with his daughter. Could it is also be seen as an *event of understanding*? His first reaction was indeed that *she* did not understand him; perhaps it is equally correct to ask whether *he* understood her. Following Cavell's own suggestions, a number of possible meanings may have been expressed in his daughter's use of the word 'kitty'. The concept may be pointing to something else, or its meaning may be shifting because of a different syntax, or it may have a wider application, and it may refer to the situation as such. He does not know, and cannot know for certain. The association belongs to Cavell as a father; it is not his daughter's words or explanations. Still, his associations seem relevant to the situations in which the word was used. It suggests possible elements of continuity and similarity between the situations. Hence, she uses the sound 'kitty' as a concept, although it does not match his concept of 'kitty'. She tests it in new contexts and these experiences correct her continued use of this concept.

Cavell might not have learnt much about kittens from the error, but he realised the possibility that he and his daughter meant something different when saying "kitty". Can we from that say that he has learned something about what she meant? Alternatively, has he learned something of what it is like to be two years old? Cavell speaks of the chapter "Vocabulary" in the "Baby book" where he makes a note: "Kitty" and the date she first used it. I agree with Cavell that the child makes conscious use of concepts and communicates with them. Cavell's initial disappointment was raised because of the question whether he actually incorrectly believed that she understood.

She did in fact use the concept incorrectly, however, the disappointment indicates also another mistake about words as such, viz. the assumption that we usually mean the same in using them. On what ground do I assume identity of meaning when we say kitten? Cavell's daughter might have misunderstood the concept "kitten". On the other hand, she does master a certain concept of 'kitten', although it does not concur with that of her father.

The situation revealed that they used their concepts differently. He suddenly discovers *another meaning in the same word.* In one respect, it is unquestioned that the child used the concept erroneously. On the other hand, he starts to guess what she might have meant and, by that, he may have touched something of how a kitten *was* seen from a *child's point of view*. Generally, there is a possibility of new knowledge simply because we mean something different while using the same words. We see things a little differently and associate it differently. We think we mean the same, so the problem is how to make this difference explicit and consequently see the standpoint of the other.

Although Cavell does not discuss this, I argue that there is still a potential for understanding in the type of situation he describes. Exactly what she meant is uncertain, but she evidently meant something else than her father, but not completely. There is a certain contact between the way his daughter uses the word and the way he and most people use it. They use the same word differently, although there are difficulties in elaborating this difference because we have no adequate meta-language in which a comparison can be made. The child did not even have opportunity to rephrase what she meant (Like: I meant by kitten what you meant by fur). How is it then possible to decide what the other means by what he/she said?

Cavell says elsewhere that the expression 'what he said', refers both to the *words* he used and to what he *meant* by using them. We can answer the question 'what did he say?' either by repeating his words or reporting his thought. An accurate quotation of what he said does not assure what he meant. Rephrasing depends on our own perception of what he meant. It has the possibility to clarify misunderstanding as well as to include interpreting the words he said. Cavell rejects the idea that reporting the exact words cannot fail to report what he said, and although 'what he said' refers both to his words and to his thought, we cannot maintain them as identical.

> If the connection between 'our words' and 'what we mean' is a necessary one, this necessity is not established by universals, propositions, or rules, but by the form of life, which makes certain stretches of syntactical utterance *assertions. (Cavell, 1979:208)*

The mere repetition of the words will also serve to conceal any difference in usage. She says 'kitten', and by that she meant 'kitten'; however, how could he then suspect that she might have meant something different? Cavell argues that Wittgenstein's methods of determining the meaning of words cannot be found in the classical search for a definition, and that they cannot assume a perspective 'outside' the world (Cavell, 1979:207). Understanding language will therefore depend on the language that we seek to understand. Furthermore, understanding each other will happen within the interaction of the dialogue itself. We cannot assume a neutral position *outside* the dialogue; however, we can make the other see what we mean from different perspectives.

When my daughter was 2 years of age, she was very fond of a particular song about a "Little song thrust" that we often sing at bedtime.[17] One Sunday, I asked her whether she wanted to walk with me into the forest. "The green one?" she asked quoting the song and continued eagerly, "Yes. I want to meet 'Little song thrust!'" After a short walk, we saw a flock of approximately 10 thrusts. I pointed to them and said, "Look! Those are thrusts. Perhaps the little song thrust is among them!" whereupon she quickly objected and said, "No, those are birds!" It suddenly occurred to me that she did not think of the "little song thrust" as a bird at all. Perhaps

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[17] Norwegian children's song (No: "Lille måltrost", Måltrost is in the thrush family): Unfortunately, an English translation is not available. The song is written by Alf Prøysen, and is about a song thrust that lives in the "green forest". She collects "food to her little ones", sings to them, is proud of her children, and takes care of them.

she had visualized the song thrust as a mother or father, one that loves his or her children and fetches food for them. What made her so happy singing the tune? A sense of belonging? Security? Comfort? The sound of the phrase 'little song thrust'? It is impossible to decide; however, we have evidently not meant the same when talking about 'song thrusts'.

Later, I showed her pictures of song thrusts and explained this to her, which resulted in some wondering and confusion. She was too young to account for it, but I noticed that it took several days before she wanted to sing "little song thrust" again, and even longer before she showed eagerness in singing it. Had I destroyed her image of a 'song thrust'? In a sense, I did exactly what Cavell did, corrected her use of the word in accordance with a common usage of the concept. In the future, I am more confident in that we at least talk about birds. However, I can also understand why she perceived "the little song thrust" differently from me. I might not have learnt anything new about birds, but it made it possible to see something from the point of view of the other, or at least to catch a glimpse of what the world looks like from her point of view. I still maintain that "song thrusts" are birds, but I admit that her understanding of the song makes sense. There are obviously other aspects that are clearly present, and which expanded my original understanding of her. This event represented foremost a sudden and unexpected possibility for me to see the world and myself from the point of view of my daughter.

There are two objections against this view of this as a fundamental example of language. First, it may be objected that it does not say anything new about how words mean, but rather about how we differentiate and account for details within an already established language. Second and consequently, the example is rather about specialising and expanding the vocabulary. *Insufficient vocabulary* will indeed delimit the capability to express what I mean, but limited vocabulary is not a principle limit of the language. It is a question of learning new words, and not a linguistic boundary that delimits what I am able to learn or what I am able to identify and recognize. There is also a difference between seeing a *bird* and knowing that it is a *song thrust*. The vocabulary is however not the primary focus here. The point is how words are used and how the discovery of difference in usage comes as a surprise and possible clarification. We project words with confidence that we master their usage. Any difference in use may reveal itself as an error. This is what Cavell describes when his daughter gradually learns to use the word. The same type of discovery can make us aware that the child perceives the same word differently. It does not expand any vocabulary, but it makes the other see something about how we *use* words to reveal our perception and understanding of the world. The misunderstanding brings about a clear perception of the other person because even simple words that may be demonstrated by pointing have the potential of different use. This belongs to language. Understanding cannot be based in clear and complete descriptions and explanations.

Understanding seems initially to break down; and at the same time, it might be a situation of clarification. The same concepts may be used differently. When this difference becomes conspicuous, it not only illuminates difference with regard to meaning; it also represents an opportunity to see how the other perceives the concept and the form of life in which the concept takes part.

Schizophrenia becomes an even more fundamental example of this because of its extraordinary features. It is true that we do not have a meta-language when speaking with children; however, we can fall back on a joint horizon of experience and life world. This is not equally evident when speaking of psychosis. It indicates two aspects of language. First, the misunderstanding of identity of meaning is revealed. The main problem might be that we lack the (childish) interest of exploration and an open examination into how the words are used. Second, we have an understanding of the unsaid that emerges even from the use of 'everyday' and very familiar concepts. This gives language a dynamic possibility, in which understanding the other also may serve to alter and expand own horizon of understanding.

Møller describes how words that try to depict psychosis are hopelessly deficient and often fall back on inadequate phrases (clichés) and statements (Møller, 2001; Møller et al., 2001). One problem in speaking of psychosis is to clarify what the different expressions might mean. Under other circumstances, this is seldom a problem because we can show what we mean, for instance, by pointing. Cavell says that pointing as such does not clarify meaning since pointing represents 'exemplary' necessity, denoting that we may "point to a meaning" by pointing to a particular object. However, pointing can be clarifying only when the act itself can transcend the particularity of the object. This places the examples in a crucial position:

> A main use of the examples about point is to show that the difference between them is not determined by a particular *feeling* which accompanies the pointing (…) but in what happened before and after, the circumstances of the act. (Cavell, 1979:75)

The "meaning" of the words is thereby placed, not in relation to a subjective perception, but in the shared life world and in a practical context in which the words are used. Acquiring a shared language cannot be disconnected for sharing life world. However, we face a problem of clarification when we have nothing to which we can point. Even though sense is established in shared language, it is problematic when we have no meta-language in which we can account for what we mean.

Either repeating the words or paraphrasing what was meant can account for what is said (Cavell, 1979:207). Without anything to display, we may soon end up in a closed circle of having nothing more to say than, “When I say ‘spade’ I mean ‘spade’”, or explanations such as, “when I say bachelor I mean a unmarried male”. In the former, nothing is added; in the latter, a certain clarification is established, although this depends upon our understanding of the ‘clarifying’ words of the definitions. Another approach is using synonyms, “When I say spade I mean shovel”. Paraphrasing and rewriting have an additional capacity to introduce new aspects and descriptions in order to clarify what we mean. We must find a way out of the circle. Eventually we must make the transition from the word to the object we speak of by using this word.

Cavell’s emphasis on the life world and shared language becomes crucial because it indicates how we grow into a language by using it. This indicates not only how we can learn new words and entire languages, but also how it depends on sharing the life world to which it belongs. In addition, Cavell illustrates how words can be used and reused in order to communicate new aspects and ideas. This process is always in progress, and the crucial point when I say that I understand the other is the process as such, and not an imagined ‘end-product’. Understanding the other does not take identity of meaning as fact, only that we participate in a meaningful interaction based on what the other has to say.

LANGUAGE OF PSYCHOSIS

LANGUAGE OF PSYCHOSIS

The language of psychosis is no language of its own. If we wish to speak of a *language of psychosis,* it must be the expressions, descriptions, and explanations related to psychosis and its experiences. Extraordinary experiences do not depend on an extraordinary language in order to be expressed; however, it is necessary to find expression in words that communicate. Since understanding is never an accomplished act but an ongoing process, the crucial question is how we deal with psychosis *within* language. The claim that psychosis is beyond understanding continues a certain perception of what it means to understand and how words make sense. It is important to investigate whether it is the *phenomena* itself or what we *think* about language that hinders understanding.

The problems of understanding psychosis are best understood within language and not in opposition to it. I have therefore chosen to treat the problems of understanding, not as belonging to a different grammar or to no grammar at all, but as arising within language and rationality as such. On the other hand, we are in fact willing to speak of psychosis in terms of incomprehensibility. Moreover, this involves not solely *communicability* but also the possibility of *interaction and co-existence.* If what the patient says does not make any difference, this lack of ability to express oneself represent a fundamental isolation from other people and a major problem for the patient.

Isolation from others is a key feature of schizophrenia. In this context, *withdrawal and exclusion* signifies complementary aspects of being alone or isolated from others. The significance and consequences of this situation is best seen within the context of everyday life. It is thus necessary to establish a description as near to the first hand perspective as possible in order to look into key concepts like illness, treatment, institutionalism, drugs, and normality.

The aim of the fieldwork was to understand and recapitulate what the patients expressed about their experiences of schizophrenia. The point of departure was an everyday context in which these expressions belong. Although this meant that the focus was placed upon the particular situation of a single rehabilitation unit and the psychiatric treatment offered there, the focus on the difficulties regarding speaking of psychosis is based on far more general structures.

We might understand a person's narrative as unrelated to reality. However, this does not offer a constructive way of dealing with the stories of the patients because it presupposes a gap that separates fiction from life. The crucial question is in what way a narrative might lead us back to actual life, experience, and self-understanding; and how we may establish a common language in which psychotic language may be meaningful.

In order to follow up this question of understanding, it is necessary to review what psychotic expressions have in common with other expressions. This means shifting the focus away from what is remarkable with the schizophrenic patient and towards what we have in common when using language to express ourselves. It is necessary to place the spoken words within the context in which they came to expression. This meant the horizon of the everyday life at the institution. The problems that patients exhibited in accounting for themselves point towards a common feature of language that is evident when we account for inner states, self-identity, and worldview. Shifting the focus away from what *characterises and delimits* schizophrenia and to what we share, could however imply that the concept of illness comes out of focus. Even though difficulties of understanding are closely related to psychosis, this does not define psychosis as phenomena or as illness. Concepts like action and intentionality describe more adequately the aspects of both health and illness . The concept of understanding, on the other hand, contributes to a fruitful perspective on the illness that actualises the problems, not in terms of causality, but in terms of (a lack of) interaction, and thus isolation from others.

De-emphasizing the distinction between psychotic language and language in general would have been difficult or even mistaken if it implied reducing the problems of schizophrenia to nothing. The traditional assessment of psychosis and incomprehensibility is thus a simpler approach since it upholds a distinction between madness and normality. This is especially evident if one maintains that we speak of these phenomena as 'madness' or 'psychotic' because they are incomprehensible. Schizophrenia is nevertheless the only concept that stands 'unchallenged' as such in this essay. This means that the use of 'schizophrenia' refers in this context solely to the criteria set forth by DSM-IV. DSM-IV describes 'schizophrenia' as a concept with a clearly correct and incorrect use. The correct use of the concept is determined by the (sufficient) presence of certain key symptoms. The major features of schizophrenia have not been questioned as such, however it has been important to look into *why* we perceive something as delusions, *how* we speak of hallucinations, and what inability means.

Psychiatry as a clinical praxis relates to psychotic patients on an everyday basis. It may include follow-up of individuals for several years. 'Psychiatry' represents more than the medical and pharmaceutical specialities. It represents a conglomerate of professions and functions. The advantage in the everyday clinical praxis is the closeness and interaction into which the staff and patients enter. This perspective implies the potential of a process-oriented view of understanding. The point has been to indicate *how this aspect of understanding* the patient *already is present in clinical praxis*, although this potential can be lost. Psychiatry as clinical praxis needs therefore a theoretical basis for upholding this view of understanding in order not to loose the potential within clinical praxis.

The 'official' knowledge and how knowledge comes to expression as explanations to clinical practice is an interesting dialectic: When you ask someone about a particular problem, they usually refer to textbook accounts or publications. However, almost immediately they may continue to explain by using *examples* in the form of case histories or speaking about particular instances. *The clinical praxis is in a certain respect, already a narrative since one continually relates to patient's life stories.* Also the staff members create their own stories. These clinically based stories are an essential part of the knowledge about the illness and treatment. The consequence of seeing psychiatry as a clinically based speciality is that clinically based experience, practice, and knowledge must also be given attention in theoretical contexts.

Both understanding and not understanding have been described as part of the perception of schizophrenia. Different concepts of understanding are used which may explain this difference. The various uses are complementary rather than mutually excluding. The various uses constitute our concept of understanding. However, this does not explain why understanding collapses when faced with what the patients actually say and do. The perception that the patient follows a path that we cannot follow is more important as a clue for our problems with psychosis.

This kind of withdrawal represents a general problem of understanding because the formation of meaning and narrative creativity depends on the interaction of doing things together, sharing a life world, sharing a language, and thus speaking together. If we do not share a language in which to describe the experiences of schizophrenia, it means that we are cut off from the life world of the other person, which can only signify a fundamental isolation for both the patient and for those who try to understand. We could cut ourselves off from the process of understanding the other before the process had even started. Being able to speak depends on having a shared language.

The private language arguments illustrate that meaning depends on language and not experience as such and how our use of words is sharpened and challenged against the words of others. Language cannot be imagined apart from this public arena. The foundation for a genuine interaction with the patient should therefore already be present as we share the language. The potential closeness in clinical practise is therefore essential.

Listening to the patient depends on a shared life world, and sharing life worlds depends on listening to what the patient has to say. This is an ongoing, dynamic, and circular process. The imagined 'end-product' or 'final understanding' is actually not as interesting or relevant as the process itself. The point of understanding this process is the dialectics between the shared language and the shared life worlds.

APPENDIX

Forespørsel om å delta i forskningsprosjekt

"Identitet og livsverden" er navnet på et filosofisk prosjekt som tar sikte på å si noe om hvordan rehabilitering oppleves av de som er involvert i prosessen (både behandlere og pasienter). "Identitet" har med hvordan man opplever seg selv. Kort fortalt har det med hva du vil svare når noen spør: "Hvem er du?" Noen ganger er det passende å oppgi navn og personnummer (f eks i banken), av og til presenterer vi oss med familiebakgrunn eller venner, det kan være sosiale roller (som yrke og utdanning), verdier eller mål man har satt seg i livet. Slike forhold utgjør til sammen et selvbilde, dvs en forståelse vi har av hvem vi selv er.

"Livsverden" er de omgivelsene som vi hver eneste dag forholder oss til. Det kan være helt alminnelige gjenstander vi tar for gitt (som klær, mat, møbler) eller ting som fascinerer oss eller vi ikke forstår. Andre mennesker er viktige i vår livsverden. En livsverden er avhengig av mennesket selv. De fleste vil si at det er stor forskjell mellom å bo på Tromsøya eller på yttersida av Kvaløya eller Senja – selv om avstanden i antall kilometer ikke er så stor. Livsverden vil også avhenge av dagsform, følelser og tanker man har om omgivelsene, slik f eks den lykkeliges verden oppleves annerledes enn den ulykkeliges.

I sammenheng med dette prosjektet vil det være interessant å snakke om slikt som hva du tenker om hjemstedet ditt, hva du tenker om vennene dine og hva som engasjerer deg (folk er jo forskjellige; man kan bli engasjert i alt fra politikk, matlaging, en hobby eller sine venner).

Andre forhold som kan være viktig vil være hva du tenker om rehabiliteringen, den kontakten du har hatt med helsevesenet og behandlere. Hva tenker du om framtiden din og f eks hvilke vanskeligheter du har støtt på underveis.

Det er viktig å si at dette ikke er en "undersøkelse" i vanlig forstand av ordet. Du er helt fri til selv å sette grensene for hva du har lyst til å fortelle og hva du helst vil holde for deg selv. Det er ikke noen målsetting ved samtalen at vi må berøre bestemte temaer. Det vi er interessert i å snakke om er ting som interesserer deg, og som du opplever som betydningsfullt i din hverdag.

All deltagelse i prosjektet er frivillig. Du vil bli forespurt via behandler ved rehabiliteringsenheten. Først ved eventuelt samtykke vil rehabiliteringsenheten opprette kontakt med prosjektleder i forskningsprosjektet. Du trenger ikke å begrunne det dersom du ikke ønsker å delta. Du kan også, når som helst, velge å trekke deg fra studien uten begrunnelse og uten at dette vil få noen konsekvenser for evt behandling eller forholdet ditt til rehabiliteringsenheten.

Den praktiske gjennomføringen vil medføre en samtale med en filosof. Vi kan møtes i ditt hjem, et kontor på rehabiliteringsenheten eller et annet sted vi finner passende. Samtalen vil ta om lag en time. Du trenger ikke å forberede noe som helst.

Filosofen vil i etterkant skrive ned sitt inntrykk fra samtalen. Du vil få en kopi. Det gjør vi for at du skal få full mulighet til å se alt det som gjelder deg som person. Du kan også kreve at innsamlede opplysninger slettes. Eller du kan be om at vi sletter eller endrer avsnitt som du ikke liker. Ingenting fra samtalen vil bli videreformidlet uten etter samtykke fra deg.

For å sikre kvaliteten på de innsamlede dataene kan det være ønskelig å ta opp enkelte samtaler på bånd. Lydbåndene og utskrifter av dem vil bli oppbevart like strengt som en legejournal. Ingen utenom forskningsleder vil ha tilgang til dem. Du kan selv kreve båndene slettet. Alle opplysninger vil dessuten bli slettet når prosjektet er sluttført i 2003.

Når prosjektet skal publiseres, vil alle opplysningene være anonymisert på en slik måte at det ikke skal være mulig å identifisere personene som gjengis. Resultatet av prosjektet vil bli gjengitt i en skriftlig oppsummering. Den vil bli formidlet til deg som har deltatt via rehabiliteringsenheten. Når prosjektet er sluttført, vil rehabiliteringsenheten også få tilsendt et eksemplar av avhandlingen som du skal ha anledning til å låne.

Det er ingen risiko ved å delta i studien. Det kan være ubehag knyttet til å snakke om egne problemer til en fremmed person. Men nettopp av den grunn er det viktig for oss at det er du som setter grensene for hva du vil fortelle. Det er heller ikke sikkert at du vil ha noen personlig nytte av å delta i prosjektet ut over det å kunne snakke med en filosof om ting man er opptatt av – mange synes jo det er interessant i seg selv. Den viktigste nytten vil være at vi i dette prosjektet skal å få sagt noe om hvordan rehabilitering oppleves fra innsiden, slik at det kan bidra til at man i framtiden kan bli enda dyktigere til å gi hjelp til mennesker som vil være i samme situasjon som deg.

Dersom du ønsker mer informasjon om prosjektet, kan du ta kontakt med prosjektleder, Geir Fagerjord Lorem (filosof), Institutt for samfunnsmedisin, Med-fak, 9037 Tromsø, tlf 77 64 65 33, e-post: geir.lorem@ism.uit.no.

Jeg har lest/er blitt forklart informasjonen om prosjektet og samtykker i å delta i studien.

Dato:..........................

Signatur:..

Jeg har lest/er blitt forklart bruken av lydbånd og samtykker i at samtalen kan registreres på denne måten.

Dato:………………………. Signatur:………………………………………………

Samtykkeerklæringen underskrives i to eksemplar.

Forsøkspersonens kopi. Denne beholder du selv.

Prosjektleders kopi. Denne beholder prosjektleder.

Geir F Lorem
ISM, Med Fak, UiTø

Deres ref.: 08.03.2000 Vår ref.: 200001940-2/IAY/400 Dato: 17.04.2000

P-REK 25/2000 IDENTITET OG LIVSVERDEN — TILBAKEMELDING FRA ETISK KOMITÉ

Prosjektet ble behandlet på møte i Regional komité for medisinsk forskningsetikk, Helseregion V 06.04.2000. I referatet heter det:
Gjennom samtaler med hermeneutisk preg med pasienter (minst 6) og behandler (minst 6 video- kasus) vil man gjøre en filosofisk analyse av psykiatrisk behandling. Prosjektet har to hoveddeler, en knyttet til rehabiliteringsenheten (Psykiatrisk senter for Tromsø og Karlsøy) der pasienter intervjues, den andre til professor Tom Andersen og hans arbeid. Det brukes ikke lydbånd. Prosjektet er et doktorgradsarbeid i filosofi.

Komiteen har følgende merknader til prosjektet:

1. Forsøkspersonene vil bli forespurt via behandler ved rehabiliteringsenheten. Komiteen forutsetter at dette innebærer at prosjektleder og –medarbeidere ikke kjenner identiteten til de forespurte før disse eventuelt samtykker til deltakelse. Det bør informeres om dette i forespørselen.
2. Deltakerne skal kunne trekke seg fra studien og skal kunne kreve innsamlete opplysninger slettet eller endret. Komiteen antar at innsamlete opplysninger derfor skal lagres i en personidentifiserbar form. Prosjektet må i så fall meldes til Norsk samfunnsvitenskapelige datatjeneste i Bergen.
3. Regional komité for medisinsk forskningsetikk er ikke et forvaltningsorgan som godkjenner eller ikke godkjenner prosjekter, men et rådgivende organ som gir uttrykk for eventuelle etiske innvendinger mot gjennomføringen av et prosjekt. En eventuell henvisning til komiteen må formuleres i samsvar med dette.

Vedtak:

Regional komité for medisinsk forskningsetikk, Helseregion V ber om prosjektleders tilbakemelding på komiteens merknader.

Hvis komiteens merknader angående forespørsel/samtykkeerklæring tas til følge, ber komiteen om å få tilsendt reviderte skriv.

Tilbakemeldingen med eventuelt revidert forespørsel/samtykkeerklæring vil bli behandlet administrativt, med mindre det reises spørsmål som må legges fram for samlet komité. Komiteen har ellers ingen innvendinger mot at prosjektet gjennomføres.

Vennlig hilsen Ingunn Ytrehus, førstekonsulent

REGIONAL KOMITÉ FOR MEDISINSK FORSKNINGSETIKK, HELSEREGION V
REK V
Universitetet i Tromsø, N-9037 Tromsø, telefon 77 64 40 00, telefaks 77 64 53 00
Ingunn Ytrehus, førstekonsulent, direkte innvalg 77 64 48 76, e-post rek-5@fagmed.uit.no

Geir Fagerjord Lorem
ISM, Med fak, UiTø

9038 TROMSØ

Deres ref.: 27.04.2000 Vår ref.: 200001940-4/IAY/400 Dato: 03.05.2000

P-REK 25/2000 IDENTITET OG LIVSVERDEN — SLUTTVURDERING - KOMITEEN HAR INGEN INNVENDINGER MOT AT PROSJEKTET GJENNOMFØRES

Vi viser til brev av 27.04.2000 vedlagt revidert forespørsel om deltakelse.

Det tas til etterretning at merknader fra komiteens behandling av prosjektet i møte 06.04.2000 er tatt til følge.

Regional komité for medisinsk forskningsetikk, Helseregion V har ingen innvendinger mot at prosjektet gjennomføres.

Det forutsettes at prosjektet er godkjent av aktuelle formelle instanser før det settes i gang.

Det forutsettes at prosjektet forelegges komiteen på nytt, dersom det under gjennomføringen skjer komplikasjoner eller endringer i de forutsetninger som komiteen har basert sin avgjørelse på.

Komiteen ber om å få melding dersom prosjektet ikke blir sluttført.

Vennlig hilsen

Ingunn Ytrehus
førstekonsulent

REGIONAL KOMITÉ FOR MEDISINSK FORSKNINGSETIKK, HELSEREGION V
REK V
Universitetet i Tromsø, N-9037 Tromsø, telefon 77 64 40 00, telefaks 77 64 53 00
Ingunn Ytrehus, førstekonsulent, direkte innvalg 77 64 48 76, e-post rek-5@fagmed.uit.no

Geir Fagerjord Lorem
Inst. for samfunnsmedisin, Det medisinske fakultet, UiTø

9037 TROMSØ

Deres ref. 13.09.2000 Vår ref. 200001940-6/IAY/400 Dato 20.09.2000

P-REK 25/2000 IDENTITET OG LIVSVERDEN — SLUTTVURDERING - KOMITEEN HAR INGEN INNVENDINGER MOT METODEENDRINGEN

Vi viser til brev av 13.09.2000 vedlagt revidert protokoll og forespørsel om deltakelse.

Saken er forelagt leder for Regional komité for medisinsk forskningsetikk, Helseregion Nord-Norge 20.09.2000.

Regional komité for medisinsk forskningsetikk, Helseregion Nord-Norge har ingen innvendinger mot metodeendringen og den reviderte forspørsel om deltakelse.

Vennlig hilsen

Ingunn Ytrehus
førstekonsulent

REGIONAL KOMITÉ FOR MEDISINSK FORSKNINGSETIKK, HELSEREGION NORD-NORGE
REK V
Universitetet i Tromsø, N-9037 Tromsø, telefon 77 64 40 00, telefaks 77 64 53 00
Ingunn Ytrehus, førstekonsulent, direkte innvalg 77 64 48 76, e-post rek-5@fagmed.uit.no

orsk samfunnsvitenskapelig datatjeneste
ORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD

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N-5007 Bergen
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http://www.uib.no/nsd

Geir Fagerjord Lorem
Institutt for samfunnsmedisin, Universitetet i Tromsø
Breivika
9037 Tromsø

Dato: 26.05.00 Vår ref: 200000636 RØ/EH Deres dato: 28.04.00 Deres ref:

VEDR. MELDING OM OPPRETTING AV PERSONREGISTER

Vi viser til melding om oppretting av personregister mottatt 02.05.2000. Meldingen gjelder prosjektet 7310: "Identitet og livsverden". Vi viser også til telefonsamtale 19.05.00.

I henhold til avtale mellom Det norske universitetsråd, Det norske høgskolerådet og Norges Forskningsråd, skal personregistre som opprettes til forskningsformål, meldes til Datafaglig sekretariat ved Norsk samfunnsvitenskapelig datatjeneste (NSD). Etter en gjennomgang av meldeskjema og dokumentasjon finner Datafaglig sekretariat at det personregisteret som opprettes vil falle inn under § 2-17 i forskrift til personregisterloven. Dette betyr at registeret fritas fra konsesjonsplikten etter § 9 i personregisterloven.

Forskningsinstitusjonens ledelse er pliktig til å føre oversikt over personregistre som er fritatt fra konsesjonsplikt. Etter avtale med Det norske universitetsråd og Det norske høgskolerådet fører Datafaglig sekretariat en slik oversikt på vegne av den enkelte forskningsinstitusjon. Forskningsinstitusjonen beholder det formelle registeransvaret i henhold til forskriftens kapittel 3, og har ansvaret for at bestemmelsene om sikring, utlevering, kopling og sletting av data etterleves.

Vilkår for konsesjonsfritak etter § 2-17 er at det er frivillig å delta, at førstegangskontakten opprettes gjennom faglig ansvarlig person ved den institusjonen respondenten er registrert, at respondentenes skriftlige samtykke til alle deler av undersøkelsen innhentes, at materialet slettes eller anonymiseres ved prosjektavslutning, og at prosjektet ikke varer mer enn fem år.

Vår vurdering er basert på følgende opplysninger fra prosjektleder:

- Formålet med prosjektet er å utarbeide en filosofisk fremstilling av selvforståelse (identitet) og omverden (livsverden og medmennesker) blant pasienter under psykiatrisk rehabilitering. Prosjektets innfallsvinkel og metode er gitt ved fenomenologien og hermeneutikken, og på denne bakgrunn gi en annen og supplerende skildring av psykiatrisk rehabilitering enn ved tradisjonell medisinsk forskning.
- Utvalget omfatter to grupper: 1) Pasienter under rehabilitering ved psykiatrisk senter for Tromsø og Karlsøy, 2) Personale ansatt ved psykiatrisk senter for Tromsø og Karlsøy.
- Den faglige ledelsen ved psykiatrisk senter for Tromsø og Karlsøy oppretter førstegangskontakt med respondentene. Dette skjer ved muntlig forespørsel om deltakelse i prosjektet, samt

ved formidling av informasjonsbrev og samtykke-erklæringen fra prosjektleder til respondentene.

- Det innhentes skriftlig samtykke til deltakelse fra alle respondentene. Samtykket skal omfatte alle deler av undersøkelsen.
- Data skal utelukkende innhentes fra respondentene selv gjennom deltakelse i intervju med prosjektleder. Det er ikke utformet noen intervju-guide, men det skal innhentes opplysninger om hvordan respondentene opplever rehabiliteringsenheten, hvilke problemer man har støtt på i behandlingsapparatet, i forhold til familie og hjemsted, hvordan man opplever seg behandlet av psykiatrien m.m..
- I intervjuene med respondentene skal det ikke innhentes opplysninger om identifiserbare tredjepersoner (klienter, ansatte, familie osv.) uten at disse er orientert om det og har avgitt samtykke.
- Innsamlete opplysninger skal anonymiseres eller slettes ved prosjektslutt, som er oppgitt til 31.12.2003.
- Datafaglig sekretariat understreker at et vilkår for konsesjonsfritak, er at respondentene skal være kompetente til å avgi reelt samtykke til deltakelse. I telefonsamtale 19.05.00 ble dette forhold diskutert med tanke på pasientgruppen i utvalget. Vi fikk opplyst at det ikke skulle rekrutteres respondenter som det var knyttet usikkerhet til i hvilken grad de var kompetente til å avgi reelt samtykke til deltakelse. Det ble avtalt at det for hver respondent som ble forespurt om deltakelse i prosjektet, skulle det først foretas en faglig vurdering av pasientens kompetanse til å avgi et slikt samtykke.

Opplegget for undersøkelsen vil ut fra dette oppfylle kravene for konsesjonsfritak. Det er grunn til å understreke at selv om det ikke er nødvendig å innhente konsesjon fra Datatilsynet, vil de alminnelige reglene i personregisterloven fremdeles gjelde.

Dersom prosjektet endres i forhold til oversendte meldeskjema og tilhørende dokumentasjon, kan det utløse konsesjonsplikt og bør vurderes på nytt av Datafaglig sekretariat.

Datafaglig sekretariat vil ved prosjektets avslutning rette en henvendelse om arkivering av innsamlet datamateriale. En slik henvendelse kommer fra oss i desember 2003. Dette blir gjort både for å sikre at data ikke blir unødvendig slettet, og for å kunne yte bistand dersom det likevel skulle oppstå behov for konsesjonsbehandling i forbindelse med lagring av datamaterialet.

Kontaktperson: Reidar Øygard, tlf. 55 58 35 42/55 58 21 17 (eksp.)

Vennlig hilsen
Datafaglig sekretariat

Bjørn Henrichsen

Reidar Øygard

cc: Institusjonen

Vedlegg: Utdrag fra personregisterloven kapittel 3 og forskrift til personregisterloven kapittel 2 og 3.

Norsk samfunnsvitenskapelig datatjeneste
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD

Hans Holmboesgt. 22
N-5007 Bergen
Norway
Tel: +47/ 55 58 21 17
Fax: +47/ 55 58 96 50
E-mail: nsd@nsd.uib.no
www.nsd.uib.no

Geir Fagerjord Lorem
Institutt for samfunnsmed.
Medisinsk fakultet, UiTø
Breivika
9037 TROMSØ

Dato: 03.11.00 Vår ref: 200000636 RØ/RH Deres dato: 13.09.00 Deres ref:

VURDERING AV KONSESJONSPLIKT FOR FORSKNINGSPROSJEKT

Vi viser til meldeskjema og vedlegg mottatt 02.05.2000 for prosjektet 7310: "Identitet og livsverden", samt til brev fra Datafaglig sekretariat 26.05.2000. I brevet fra oss konkluderte vi med at prosjektet kunne fritas for konsesjonsplikt etter § 2-17 i personregisterloven.

Vi har mottatt nytt brev, der det opplyses om at det vil bli gjort noen endringer i opplegget for registrering av innsamlede opplysninger i prosjektet. Det opplyses at disse endringene innebærer at det vil bli brukt båndopptaker under intervjuene og at materialet skal transkriberes til edb og deretter lagret digitalt (CD-rom).

Etter gjennomgang av de tilleggsopplysninger som er gitt, er det vår vurdering at prosjektet fortsatt vil kunne fritas for konsesjonsplikt etter § 2-17 i personregisterloven. Dette under forutsetning av at vilkårene i brev fra oss av 26.05.00 fortsatt kan oppfylles.

Dersom noe skulle være uklart, ta gjerne kontakt med Datafaglig sekretariat, tlf. 55 58 21 17 (eksp.).

Vennlig hilsen
Datafaglig sekretariat

Bjørn Henrichsen

Reidar Øygard

orsk samfunnsvitenskapelig datatjeneste
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Geir Fagerjord Lorem
Institutt for samfunnsmed.
Medisinsk fakultet, UiTo
Breivika

9037 TROMSØ

Dato: 25.09.2001 Vår ref: 200000636 AGM/RH Deres ref: Deres dato:

PROSJEKTER SOM ER MELDEPLIKTIGE ETTER § 2-17

7310 Identitet og livsverden

Prosjektet er tidligere blitt vurdert av NSD som meldepliktig etter § 2-17 i personregisterloven. Denne henvendelsen kommer som en følge av at personregisterloven 01.01.2001 ble erstattet av personopplysningsloven. Prosjektet faller nå inn under bestemmelsene i den nye loven som er trådt i kraft. Det betyr at:

1. Dersom prosjektet ikke er avsluttet innen 31.12.2001 og det fremdeles arbeides med eller oppbevares personopplysninger, dvs. opplysninger som kan knyttes til enkeltpersoner, må det fylles ut et nytt meldeskjema slik at prosjektet kan vurderes i forhold til den nye personopplysningsloven. Meldeskjemaet er tilgjengelig på Internett, http://www.nsd.uib.no/personvern/meldeskjema.doc, eller kan fås tilsendt ved å ta kontakt pr. telefon.

2. Dersom datamaterialet er anonymisert innen 31.12.2001, er det ikke nødvendig å fylle ut meldeskjema.

Dersom prosjektet er avsluttet, må det tas stilling til hvordan prosjektdata skal arkiveres. Data som er egnet for arkivering hos NSD er kvantitative data samlet inn, produsert eller tilrettelagt for et forskningsprosjekt. Dette kan være data fra for eksempel spørreundersøkelser, intervjuundersøkelser, registerundersøkelser, kliniske undersøkelser, observasjoner og tester. Prosjekter som er finansiert av NFR er pliktige til å arkivere data hos NSD. Derfor må det redegjøres skriftlig dersom man ikke ønsker arkivering.

For at mulighetene for gjenbruk av prosjektdata skal være reelle, må datasettet dokumenteres før overføring. NSD har utarbeidet et eget dokumentasjonsskjema for dette formålet. Skjemaet er tilgjengelig på Internett, http://www.nsd.uib.no/personvern/arkiv.html, eller kan fås tilsendt ved å ta kontakt pr. telefon. Dokumentasjonsskjema sendes til NSD sammen med datafilene og annen relevant dokumentasjon (intervjuguide/spørreskjema, kodebok, rapport, etc.).

Vi ber om tilbakemelding innen 10.10.2001. Ta gjerne kontakt dersom noe er uklart.

Vennlig hilsen
Datafaglig sekretariat

Alette G Mykkeltvedt

Bjørn Henrichsen Alette Gillhus Mykkeltvedt

Kontaktperson: Alette Gillhus Mykkeltvedt, tlf.: 55 58 35 42

lorsk samfunnsvitenskapelig datatjeneste
ORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD

Hans Holmboesgt. 22
N-5007 Bergen
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Tel. +47/ 55 58 21 17
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Geir Fagerjord Lorem
Institutt for samfunnsmedisin
Universitetet i Tromsø
Breivika
9037 TROMSØ

Vår dato: 12.10.2001 Vår ref: 200000636 AGM/ RH Deres dato: 08.10.2001 Deres ref:

FORSKNINGSPROSJEKT SOM OMFATTES AV MELDEPLIKT

Vi viser til melding om behandling av personopplysninger, mottatt 08.10.2001. Meldingen gjelder prosjektet:

8726 Identitet og livsverden

Etter gjennomgang av meldeskjema og dokumentasjon, finner Datafaglig sekretariat at opplegget for undersøkelsen fyller kravene for meldeplikt i henhold til personopplysningsloven (POL) § 31. Datafaglig sekretariat har sendt melding om prosjektet til Datatilsynet 12.10.2001. Datatilsynet vil i løpet av 1-2 uker sende kvittering til behandlingsansvarlig for mottatt melding.

Dersom undersøkelsesopplegget endres i forhold til innsendt meldeskjema, skal prosjektet vurderes på nytt av Datafaglig sekretariat.

Det gjøres forøvrig oppmerksom på at det skal gis ny melding tre år etter at forrige melding ble gitt, dersom prosjektet fortsatt pågår, jf. § 31 tredje ledd.

Vennlig hilsen
Datafaglig sekretariat

Bjørn Henrichsen

Alette Gilhus Mykkeltvedt

Vedlegg: Utdrag fra POL §§ 31 og 33 og forskriftenes kapittel II §§ 7-20 og 7-25.

Kontaktperson: Alette Gilhus Mykkeltvedt tlf: 55 58 35 42

Datatilsynet

Geir Fagerjord Lorem/Inst. For samf.med./
Universitetet i Tromsø
Breivika
9037 TROMSØ

Deres ref	Vår ref (bes oppgitt ved svar)	Dato
	KBK/ltw	24.10.01

KVITTERING FOR MOTTATT MELDING I HENHOLD TIL PERSONOPPLYSNINGSLOVEN § 31

I overensstemmelse med personopplysningsloven § 31, 2.ledd, 2. punktum, gis med dette kvittering for mottak av en melding om behandling av personopplysninger datert 19.09.01.

Datatilsynets referansenummer på meldingen er: 1405
Vi gjør oppmerksom på at denne kvittering bare er en bekreftelse på at Datatilsynet har mottatt meldingen. Kvitteringen er ikke et uttrykk for at Datatilsynet har vurdert om behandlingen av personopplysninger tilfredsstiller kravene i personopplysningsloven. Den behandlingsansvarlige er selv ansvarlig for at disse kravene er oppfylt.

Den innmeldte behandling av personopplysninger kan igangsettes eller fortsette ved mottak av denne kvittering.

Datatilsynet gjør oppmerksom på at den behandlingsansvarlige må sende ny melding i henhold til personopplysningsloven § 31 tredje ledd. Bestemmelsen har følgende ordlyd:

> *"Ny melding må gis før behandling som går ut over den rammen for behandling som er angitt i medhold av § 32. Selv om det ikke har skjedd endringer, skal det gis ny melding tre år etter at forrige melding ble gitt".*

Meldingens innhold vil være offentlig tilgjengelig, i overensstemmelse med personopplysningsloven § 42 annet ledd nr 1.

Med hilsen

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ISM SKRIFTSERIE - FØR UTGITT:

1. Bidrag til belysning av medisinske og sosiale forhold i Finnmark fylke, med særlig vekt på forholdene blant finskættede i Sør-Varanger kommune.
Av Anders Forsdahl, 1976. (nytt opplag 1990)

2. Sunnhetstilstanden, hygieniske og sosiale forhold i Sør-Varanger kommune 1869-1975 belyst ved medisinalberetningene.
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3. Hjerte-karundersøkelsen i Finnmark - et eksempel på en populasjonsundersøkelse rettet mot cardiovasculære sykdommer. Beskrivelse og analyse av etterundersøkelsesgruppen.
Av Jan-Ivar Kvamme og Trond Haider, 1979.

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Av Olav Helge Førde og Dag Steinar Thelle, 1979.

5\. D. Reformer i distriktshelsetjenesten III: Hypertensjon i distriktshelsetjenesten.
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6\. Til professor Knut Westlund på hans 60-års dag, 1983.

7.* Blodtrykksovervåkning og blodtrykksmåling.
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9\. "Balsfjordsystemet." EDB-basert journal, arkiv og statistikksystem for primærhelsetjenesten.
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15. Til Anders Forsdahls 60-års dag, 1990.

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33. D. The Harstad injury prevention study: Hospital-based injury recording and community-based intervention.
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34.* D. Vilkår for begrepsdannelse og praksis i psykiatri.
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