Demystifying phenomenological and social psychiatry

Contents

Introduction

With the social context of psychiatry experiencing a renaissance of interest from a younger generation of aspiring professionals, the need to create clarity in the vast spectrum of associated themes arises. To be sure, such an overview will in itself cause certain problems due to its simplification of the matters at hand. But let us deal with these problems, if and when they arrive, once a certain foundation of understanding is laid.

For this purpose, the theoretical, in part phenomenological, context will be portrayed first and a discussion of institutional and methodological aspects of social psychiatry will follow. This order seems logical for two reasons: first, it seems intuitive to begin with the theory prior to indulging in the practice. Second, more importantly, it highlights a common cause of misunderstanding associated with institutional social psychiatry, namely a complete lack of theoretical substance.

Before commencing on the aforementioned path, a terminological difficulty must be addressed: *social* vs. *community psychiatry* (in German: ‘Sozial’- vs. ‘Gemeindepsychiatrie’). Some authors have attempted to dismantle the division.[1] Others construe it as follows: ‘social psychiatry’ describes a point of view, as subject orientation from a social perspective, while ‘community psychiatry’ encompasses a practical realisation of this aim, as the practise of psychiatry in the wider community.[2] The separation is more commonly accepted, yet a satisfactory, universal terminological solution to this issue is outstanding. In this sense, let this schism merely be noted here for future consideration.

---

[1] Maxwell Jones — *Social Psychiatry in Practise. The Idea of the Therapeutic Community.* Penguin Books, 1968, pp. 29-31
[2] Ibid.; also, see Samuel Thoma — *Common Sense und Verrücktheit im sozialen Raum.* Köln: Psychiatrie Verlag, 2018, p. 34

Theoretical aspects

Philosophical considerations: phenomenology and anthropology

Phenomenology seeks to provide an account of the structures which make a shared, objective world intelligible. What unifies the tradition of phenomenology is a common preoccupation with comprehending the intelligibility of the world and all things, such as objects, within it. In other words: how the world manifests itself to us; the structure of experience. Phenomenologists want to decipher by which means we perceive the appearance of objects, activities and events — in essence, how reality presents itself. To do so, the content of such appearances must be considered, whereby the phenomenological method is conceived: we can understand appearances by a careful, descriptive elucidation of their underlying structure, i.e., by going 'back to the things themselves'. These structures may be immanent, as in the cognitivist tradition of the pure, transcendental phenomenology of Kant and Husserl, or else necessarily embodied, as in the existential phenomenology of Heidegger, Sartre and Merleau-Ponty.

With regard to the isolated field of anthropology, Gregory Bateson summarises: "it is [the anthropologist's] task to see the highest common factor implicit in a vast variety of human phenomena, or inversely, to decide whether phenomena which appear to be similar are not intrinsically different."[3] David G. Cooper attempts to describe the relevance of anthropology to psychiatry by contrasting a *natural science* of inert[4] careful observation with an *anthropological science* — a science of persons. He maintains their differing ontological status: "the observer-observed relation in a science of persons is ontologically continuous (subject-object *vis-à-vis* subject-object), whereas in natural sciences it is discontinuous (subject *vis-à-vis* object) permitting a purely exterior description of the field of the observed."[5]

Taking these definitions together, it is possible to comprehend the intersection between phenomenology, anthropology and psychiatry. Following Samuel Thoma: "But now what does phenomenological anthropology mean, and what is its significance for psychiatry? Due to its orientation on the concrete experience, phenomenology collates and surpasses all other access to human beings by merit of the decisive question: 'Who are we?'. On the one side, this question […] refers to the existential instant of being human in the sense of: 'Who are we *ourselves?* — And nobody else'. On the other side, I maintain that this question has a special meaning for psychiatry: the 'we'

---

[3] Gregory Bateson — *Steps to an Ecology of the Mind.* The University of Chicago Press, 1972, p. 161

[4] In the sense of being 'grasped from the exterior by an observer who is not disturbed by them and does not disturb them by the process of his observation', D. G. Cooper — *Psychiatry and Anti-Psychiatry*. Tavistock Publications, 1967. p. 4

[5] Ibid., pp. 3-6

is no *pluralis maiestatis*[6], but refers to the social instant of a *dialogue* and the *handling of madness* in a shared situation — a dialogue which, with regard to social psychiatry, is expanded to a *trialogue* thereafter incorporating the social space: 'Who are we in the encounter with madness?'" (tr. MR)[7]

Anti-Psychiatry

The term 'anti-psychiatry' was coined by Cooper in 1967[8], describing a counter-cultural movement in psychiatry that had begun in the 1950s. Broadly speaking, it was a movement critical of conventional psychiatric practise: electroconvulsive therapy (ECT), insulin-shock therapy and brain lobotomy, as well as the use of antipsychotic drugs and other measures such as involuntary commitment and forced restraint. Individuals commonly associated with anti-psychiatry are Thomas Szasz, R. D. Laing, and Cooper, as well as (indirectly) Michel Foucault, Franco Basaglia and Erving Goffman. The overall notion is often reduced to a negation of mental illness, as expressed in the title *The Myth of Mental Illness.*[9] This does not do anti-psychiatry justice, for there are certain elements tangible in social psychiatric practise today. In particular, an emphasis on humaneness and the social character of madness remain of considerable relevance[10] (inspiring, amongst others, Soteria houses — see below), as well as a phenomenological conviction underpinning the approach.[11] Basaglia highlighted the following as his guiding principle, labelling it an anti-psychiatric approach: "From the moment in which we reject our social assignment, we also abandon the thesis of the incurability of [mental] illness and desert our roles as prison officer and guardian of social order." (tr. MR)[12]

Other elements of anti-psychiatric treatment such as the strict rejection of medication have received less approval in modern psychiatric care. Further, psychedelic therapy (hallucinogen-supported psychotherapy)[13] is often associated with anti-psychiatry due to the adoption of such treatment methods in alternative therapeutic settings, such as *Kingsley Hall*[14] in London. This method of therapy is largely rejected and remains illegal in most countries. As a result, further research in this direction is generally prohibited.

---

[6] Latin for 'royal we'. Used in place of 'I' to refer to oneself, typically by a person in a high office such as a pope or monarch. See the 'royal we' Wikipedia entry — https://en.wikipedia.org/wiki/Royal_we

[7] Samuel Thoma — *Common Sense und Verrücktheit im sozialen Raum.* Köln: Psychiatrie Verlag, 2018, pp. 40-42. Note: an english translation of the text does not yet exist, personal translation here by MR

[8] D. G. Cooper — *Psychiatry and Anti-Psychiatry*. Tavistock Publications, 1967

[9] Thomas Szasz — *The Myth of Mental Illness.* Harper & Row, 1961

[10] Samuel Thoma — *Common Sense und Verrücktheit im sozialen Raum.* Köln: Psychiatrie Verlag, 2018, pp. 33-34

[11] For example, see R. D. Laing — *The Divided Self*. Penguin Books, 2010 (first published 1960)

[12] Franco Basaglia (Hrsg.) — *Die negierte Institution oder Die Gemeinschaft der Ausgeschlossenen. Ein Experiment der psychiatrischen Klinik in Görz.* Suhrkamp Verlag, 1968, pp. 28-29

[13] For an in-depth introduction to psychedelic therapy, see Rahel Nicolet's entry on *isolatarium.org*: 'Einführung in die Psycholyse'

[14] See footnote 25 below

Neuropsychiatry

In a sense, neuropsychiatry is an umbrella term for a range of sub-specialities postulating the following premise: *psyche* = brain, therefore psychiatric illness = brain illness — in other words: *mental disorders are brain disorders*.[15] This has guided an abundance of research over recent years, particularly the neurobiological search for biomarkers and abnormalities in brain morphology to explain psychopathological changes found in psychiatric patients.

Many critics, primarily from the field of phenomenological psychiatry (see above) and social psychiatry (see below), point to a complete failure to discover reliable neurobiological correlates of a range of symptoms (with the exception of Alzheimer's disease). Instead, they advocate the conception of psychiatric disorders as intersubjective illnesses, thus an illness of one person resulting from their relation with others.[16]

Terminology: 'social psychiatry' and 'socialpsychiatry'

This differentiation is especially important in the German language, where the terms ('soziale Psychiatrie' vs. 'Sozialpsychiatrie') are commonly used interchangeably despite some historically divergent meanings. 'Social psychiatry', as a further specification, presupposes a form of psychiatry which is not social, or even antisocial. In contrast, the term 'socialpsychiatry' serves to discriminate from other sub-disciplines of psychiatry, such as neuropsychiatry (see above). Again following Thoma,[17] 'social psychiatry' pertains predominantly to public health, thus a demand for greater emphasis on the social aspect of clinical practise. 'Socialpsychiatry' in turn describes a theoretical and practical science and, importantly, a fundamental attitude towards the social dimension of psychiatric disorders. This distinction is not commonly made in the english language due to the infrequent use of the term 'socialpsychiatry'. Once again, let this schism be merely noted here for future consideration.

Embodied and enactive cognition

Stephan Käufer and Anthony Chemero offer the following definitions in their introductory book on phenomenology,[18] supplemented here with definitions by Laura Galbusera and Thomas Fuchs:[19]

Embodied cognitive science: A combination of Gibson, Heidegger and Merleau-Ponty's views with computational cognitive science. According to embodied cognitive science, cognition is a kind of computation, in which some of the computational operations are done by using the

[15] Thomas Fuchs — *Zwischen Psyche und Gehirn. Zur Standortbestimmung der Psychiatrie.* Keynote lecture at the DGPPN Kongress 2016, Berlin
[16] Ibid.
[17] Samuel Thoma — *Common Sense und Verrücktheit im sozialen Raum.* Köln: Psychiatrie Verlag, 2018, pp. 30-33
[18] Stephan Käufer and Anthony Chemero — *Phenomenology: An Introduction.* Polity Press, 2015, p. 218
[19] Laura Galbusera and Thomas Fuchs (2013). "Embodied understanding: Discovering the body from cognitive science to psychotherapy." *Mind Italia, V*, pp. 1-6

body. Further, cognitive processes are always formed and influenced by the whole body system. This thesis stems from the assumption that minds are embedded in our bodies and our bodies are in turn embedded in the surrounding environment.

Enactivism: Initiated by Varela, Thompson and Rosch in 1991, enactivism is a theory that construes cognition as the activity through which living things bring forth a significant world, one filled with meaning. It shares the basic assumptions of embodied cognition, i.e., that the mind cannot be understood as separated from the body. Rather, embodiment and subjective experience of the world play a fundamental role in constituting and defining the cycles of perception, cognition and action.

As these definitions show, the embodied and enactive cognition approaches are related more to the phenomenological tradition than to social psychiatry. They have clinical relevance particularly in varying forms of psychotherapy such as body-oriented psychotherapy.[20]

Institutional and methodological aspects

Milieu therapy

Following David Rioch and Alfred Stanton,[21] milieu therapy "refers to procedures directed toward modification of the environmental part of the patient-environment process with a view to facilitating more satisfactory patterns of interaction." The necessity underpinning milieu therapy is in turn summarised by the following insight by Stanton and Morris Schwarz: "Psychotherapy is a technique now widely practised and studied and one held in high prestige. In contrast, administrative psychiatry, the influencing of 'the other twenty-three hours' of treatment, is more widely practised but is little studied and is of relatively low prestige."[22]

Robert N. Rapoport distinguishes narrowly defined administrative psychiatry from a broader concept of the therapeutic milieu:[23] the former attempts to combine therapeutic goals with the patient's hospital life, whilst the latter is concerned with the overall atmosphere of the institution

[20] See, for example, Thomas Fuchs and Frank Röhricht (2017). "Schizophrenia and intersubjectivity: An embodied and enactive approach to psychopathology and psychotherapy." *Philosophy, Psychiatry and Psychology,* **24** (2), pp. 127-142; Frank Röhricht (2009). "Body oriented psychotherapy–the state of the art in empirical research and evidence based practice: a clinical perspective." *Body, Movement and Dance in Psychotherapy — An International Journal for Theory, Research and Practice, **4***, pp. 135–56

[21] David Rioch & Alfred Stanton (1953). "Milieu Therapy." *Psychiatry*, **16** (1), pp. 65-72

[22] Alfred Stanton and Morris Schwarz — "The mental hospital: A study of institutional participation in psychiatric illness and treatment." New York: Basic Books, 1954; Robert N. Rapoport — *Community as Doctor. New Perspectives on a Therapeutic Community.* Tavistock Publications, 1960, pp. 19-24

[23] Robert N. Rapoport — *Community as Doctor. New Perspectives on a Therapeutic Community.* Tavistock Publications, 1960, pp. 19-24

as such. In order to be therapeutic, Schwarz postulates, a milieu must provide the contexts and facilities that may foster the following:[24]

a. Provide the patient with experiences that will minimise their distortions of reality
b. Facilitate their realistic and meaningful communicative exchange with others
c. Facilitate their participation with others so that they derive greater satisfaction and security therefrom
d. Reduce their anxiety and increase their comfort
e. Increase their self-esteem
f. Provide them with insight into the causes and manifestations of their mental illness
g. Mobilise their initiative and motivate them to realise more fully their potentialities for creativity and productivity

This shows a therapeutic milieu is the basis for all social psychiatric approaches, which may then be expanded on to suit more specific therapeutic institutions, such as a therapeutic community or Soteria houses. These will now be discussed in more detail.

Therapeutic community[25]

T. F. Main coined the term 'therapeutic community' (TC)[26] as both a manner and method of psychiatric care shortly after World War Two, highlighting institutional deficits of conventional hospitals which may thus be addressed: "The concept of a hospital [means] that patients are robbed of their status as responsible human beings […] making them 'patients' […] in a state of retirement from society."[27] However, it was under Maxwell Jones' influence in the 1950s that the TC concept gained support, becoming a replicable method with certain characteristics[28] — small size of no more than 100 persons, daily community meetings,[29] and the psychodynamic hypothesis as an underlying philosophy.

---

[24] Ibid., p. 20

[25] For a further discussion of the therapeutic community concept and its potential future relevance, see the accompanying essay to this article on *isolatarium.org*: 'Envisioning a future for psychiatric care'

[26] An in-depth description of the history of TCs, including the distinction between the 'TC proper' (equated to the shortened form TC for the current purpose) and 'alternative asylum TC', is given by Kylie Innocente: "A historical and phenomenological study of Bradley Gardens therapeutic community (1980-1984)." As it is not possible to find this online, please contact us if you wish to receive a copy

[27] T. F. Main (1946). "The hospital as a therapeutic institution." *Bulletin of the Menninger Clinic*, **10**, 66-70

[28] D. H. Clark (1964). "The Therapeutic Community — Concept, Practice and Future." *British Journal of Psychiatry*, **111**, pp. 947-954

[29] Maxwell Jones (1959). "Towards a clarification of the 'therapeutic community' concept." *British Journal of Medical Psychology,* **32** (3), 200-205

Rapoport's study of the Social Rehabilitation Unit[30] at Belmont Hospital under Maxwell Jones' leadership offers further insight into common elements of a TC. He summarises six points:[31]

a. The total social organisation affects therapeutic outcome
b. The total social organisation is not merely a background routine, but in itself a tool for treatment
c. 'Democratization' — patients partaking in the daily affairs of the institution
d. All relationships within the institution are considered potentially therapeutic
e. The atmosphere / emotional climate is therapeutically important
f. A high value is placed on communication as such.

Soteria

'Soteria' comes from the Greek word *σωτηρία* which means 'salvation' or 'deliverance'.[32] The name was given to a research project (1967-1971) by Loren Mosher, resulting in the opening of the first Soteria house in California as a therapeutic social environment for patients newly diagnosed with schizophrenia. Its initial purpose was to serve as an alternative to the 'conventional wisdom' in place across psychiatric hospitals.[33] Mosher gives the following explanation: "Basically, the Soteria method can be charaterized as the 24 hour a day application of interpersonal phenomenologic interventions by a nonprofessional staff, usually without neuroleptic drug treatment, in the context of a small,[34] homelike, quiet, supportive, protective, and tolerant social environment."[35] Thus first and foremost, Soteria is a residential community with a primary focus on 'being-with' and 'standing by attentively'.[36]

Luc Ciompi introduced Soteria to Europe opening the first house in Bern, Switzerland, in 1984. Since then, many more Soteria houses have opened across Europe, notably in Munich, Berlin and elsewhere across Germany. As noted by Mosher, "Soteria lives, and thrives, admittedly as variations on the original theme, in Europe."[37] These variations become particularly visible in the use

---

[30] There is an interesting debate on the use of 'treatment' vs. 'rehabilitation', see Robert N. Rapoport — *Community as Doctor. New Perspectives on a Therapeutic Community.* Tavistock Publications, 1960, ch. 1 pp. 9-34

[31] Robert N. Rapoport — *Community as Doctor. New Perspectives on a Therapeutic Community.* Tavistock Publications, 1960, pp. 22-23

[32] Loren Mosher (1999). "Soteria and Other Alternatives to Acute Psychiatric Hospitalization. A Personal and Professional Review." *The Journal of Nervous and Mental Disease,* **187**, pp. 142-149

[33] Ibid. pp. 2-4

[34] Usually there is space for around 8-12 patients, this being an important difference to the TC introduced above

[35] Loren Mosher (1999). "Soteria and Other Alternatives to Acute Psychiatric Hospitalization. A Personal and Professional Review." *The Journal of Nervous and Mental Disease,* **187**, p. 4

[36] Ibid. p. 5; Daniel Nischk, Philippe Merz & Johannes Rusch (2014). "Aktuelles aus der Soteria — Die Förderung lebenspraktischer und sozialer Fertigkeiten von Menschen mit Schizophrenien aus phänomenologischer Sicht." *Psychiatrische Praxis*, **41**, pp. 45-49

[37] Ibid. p. 13

of antipsychotic drugs (in many Soteria's a cautious use is now common practise)[38] and in the role and background of the staff, which may be trained mental health professionals.[39]

Institutional Psychotherapy (IP)[40]

Commonly considered as conceptional founders of Institutional Psychotherapy (IP) are François Tosquelles, Jean Oury, Hermann Simon, Frantz Fanon and George Canguilhem. Their work built upon the theory of Jacques Lacan, which was later complemented by Félix Guattari and Gilles Deleuze. Many of these individuals were heavily influenced by the experience of occupation during World War Two; of totalitarian oppression on either side of France. Such personal experiences of incarceration engendered the rethinking of institutional confinement within the psychiatric field, which became a central element to IP. Likewise these individuals had a shared conviction that social and psychological problems should be simultaneously broached, and not studied or treated independently. Within the institution this was addressed through a horizontal, radically democratic therapeutic approach. Two important examples are *Saint-Alban* in southern France, where IP was initially conceptualised, and *La Borde Clinic* south of Paris — founded by Jean Oury in 1951 and still open today.

Camille Robcis offers an insight into the anti-authoritarian therapeutic practises at *Saint-Alban*:

> *'One of the most important innovations was the Club Paul Bavet. The club was a patient-run cooperative, a sort of union, in charge of organising all the activities within the hospital. Elected and composed of various sub-committees, the club planned meals, theatre and musical performances, sports, parties and field trips — social activities deemed integral to the cure… It also ran the library and the different ergotherapy stations. As one observer noted, the atmosphere at the 'Club Paul Bavet' resembled a lively cafe, where everybody discussed all the time… The club was responsible for the publication of a weekly journal called 'Trait d'Union' — a collection of texts which could be theoretical, literary, poetic, drawing, recipes,*

---

[38] Daniel Nischk, Philippe Merz & Johannes Rusch (2014). "Aktuelles aus der Soteria — Die Förderung lebenspraktischer und sozialer Fertigkeiten von Menschen mit Schizophrenien aus phänomenologischer Sicht." *Psychiatrische Praxis*, **41**, p. 45

[39] Luc Ciompi and Loren Mosher (2004). "Soteria Critical Elements." Unpublished, available online under: http://psychrights.org/education/SoteriaCriticalElements.pdf. Further, see the staffing of contemporary Soteria houses, such as Soteria Berlin: https://www.alexianer-berlin-hedwigklinik-en.de/sthedwig-krankenhaus/leistungen/kliniken/psychiatrie-und-psychotherapie/leistungsangebote-psychiatrie-psychotherapie-und-psychosomatik/soteria/

[40] Note: this is an addendum from July 2019 to the original article published in January 2019. As should become apparent, the future TC depicted before *(isolatarium.org, 4/2018)* is probably most closely aligned with the therapeutic model of IP established at Saint-Alban. However, as the author was not aware of Institutional Psychotherapy prior to writing this addendum (further proof of its lacking influence in the english- and german-speaking psychiatric fields), it regrettably does not feature there at all, nor elsewhere in this article. Due to the philosophical depth in the theory underpinning the IP approach, it is difficult to provide a short, concise overview. Again, this is further complicated by the lack of translations of some of the key texts from original French. Thus this should be regarded as a mere introduction, in no way complete

advertisements and letters. The editorial board was composed of patients, who were helped by a few staff members, and the journal was published in the hospital itself by the printing and binding committee. Once again, 'Trait d'Union' had both a theoretical and a practical goal: the content was informational, but also philosophically stimulating… The club also coordinated the different activities for the patients that Tosquelles, following Simon, considered foundational to the cure. The work was divided into three categories: agricultural (food picking, working on the land etc.), hospital-related (masonry, carpentry, painting, cooking etc.) and ergotherapy stations (pottery, book-binding, woodwork etc.) … The club, the journal and the activities at Saint Alban were all designed to facilitate the emergence of a horizontal collectivity, a new space of transference (transferential constellation / transversality). Although the patients also received one-on-one psychoanalytic sessions with doctors, they were invited to participate in the general meetings, which had an explicit therapeutic goal [that] were strictly anti-authoritarian.'[41]

Open dialogue

The 'open dialogue' is part of a range of changes which have been introduced in Finland's Lapland under a 'Needs-adapted treatment' concept.[42] The central elements of the open dialogue method, primarily for the treatment of acutely psychotic patients, are highlighted by Volkmar Aderhold and Nils Greve:[43] "The therapy assembly as an encounter between everyone involved constitutes the central therapeutic intervention. It functions as an informative, diagnostic and therapeutic element alike: the participants become familiar with all sides of the problems discussed, the therapists can develop an idea of possible solutions, which in turn can be discussed with all participants present. At the end, all of the topics discussed and possible decisions made are summarised. A meeting of this sort usually lasts for 1.5 hours, if needed longer, and over time often shorter." (tr. MR)

Further, seven therapeutic principles of an *open dialogue* are described by Jaakko Seikkula and Birgitta Alakare:[44]

a. Immediate help within 24 hours in the form of a network meeting

---

[41] Camille Robcis — *The Politics of the Psyche.* Lecture at the Center for 21st Century Studies, 10.03.2017 (approx. 43:00 - 46:00). For further reading see IP addendum (isolatarium.org*, 3/2019)*

[42] See, for example, Volkmar Aderhold (2004). "Was ist 'Need-adapted Treatment' Das Modell zur bedürfnisangepassten Behandlung von Menschen mit schizophrenen Psychosen." *Soziale Psychiatrie*, 1/2004; Seikkula, Alakare, Aaltonen: "Offener Dialog in der Psychosebehandlung – Prinzipien und Forschungsergebnisse des West-Lapplandprojekts", in: Volkmar Aderhold et al. (Hrsg.): "Psychotherapie der Psychosen – Integrative Behandlungsansätze aus Skandinavien", *Psychosozial Verlag,* 2003

[43] Volkmar Aderhold und Nils Greve (2009). "Bedürfnisangepasste Behandlung und offene Dialoge." Available online under: http://www.offener-dialog.de/downloads/aderholdgreve_beduerfnisangepasste_behandlung.pdf

[44] Jaakko Seikkula and Birgitta Alakare. "Offene Dialoge." In *Lehmann, P., Stastny, P. (Hrsg.). Statt Psychiatrie* 2 (2007); Volkmar Aderhold und Nils Greve (2009). "Bedürfnisangepasste Behandlung und offene Dialoge."

b. Integration of the patient's social network, including family, friends, doctors, carers, etc.
c. Flexible attitude towards the patient's needs
d. Collective responsibility of a range of professions, ensuring decision making facilitates processes and not isolated measures
e. Psychological continuity, i.e., avoiding a discontinuation of therapy as well as changes in the therapeutic team
f. Toleration of uncertainties, thereby avoiding premature diagnoses
g. Promoting an active dialogue within the patient's social network

Trialogue (incl. psychosis seminars)

A trialogue in psychiatric care refers to the conversation between patients, family or friends and mental health professionals[45] (in German: Betroffene, Angehörige, psychiatrisch Tätige). The trialogical framework has been adapted for a range of interactions[46] such as lectures,[47] therapeutic concepts (see open dialogue above), conferences, and psychosis seminars, which will now be explored in greater detail.

Psychosis seminars were first established in Hamburg, Germany, in 1989.[48] A co-founder of the psychosis seminar, Thomas Bock, and Stefan Priebe give the following characterisation:[49]

a. Psychosis seminars are held on neutral grounds — that is, in premises outside of where services are provided and outside of consumer or family member organisations
b. They are held after office hours and are open to all interested consumers (patients), family members, and mental health professionals (the three groups in a trialogue)
c. They usually last for about two hours and include a break
d. They are held regularly and are arranged over a longer period. Most often, the seminars are held once every two weeks and continue for 4 to 12 months. At the end of a cycle there is a break, after which a new seminar may be started with old and new participants
e. They have topics that are jointly agreed upon. In practice, the content of programs can vary substantially
f. They are chaired by one or more of the participants. Often the chair rotates between participants of the three groups
g. They are usually attended by between 20 and 60 people (ideally with equal representation from each group)

---

[45] Elsewhere referred to as 'consumers, family members and mental health professionals', see Thomas Bock and Stefan Priebe (2005). "Psychosis Seminars: An Unconventional Approach." *Psychiatric Service*, **56** (11), pp. 1441-1443

[46] For a full list see Thomas Bock et al. (2012). "Trialog und Psychosenpsychotherapie." *Psychotherapeut*, **57** (6), pp. 514-521

[47] For example the anthropological psychiatry lecture series organised by *Irre menschlich Hamburg e.V. (irremenschlich.de)*

[48] Thomas Bock (Hrsg.) — *Abschied von Babylon*. Bonn: Psychiatrie Verlag, 1994, pp. 282-285

[49] Thomas Bock and Stefan Priebe (2005). "Psychosis Seminars: An Unconventional Approach." *Psychiatric Service*, **56** (11), p. 1441

h. They offer no form of medical treatment. Participants from all three groups attend out of personal interest and in their spare time
i. Their aim is a mutually respectful trialogue, which allows participants to learn from each other's perspectives and experiences. In this encounter, everyone is regarded as an expert with regard to their own role and experience.

Conclusion

To conclude, I want to return to the opening claim of a near complete lack of theoretical substance supposedly implemented in social psychiatric approaches. This misunderstanding has hopefully now been dissolved. As the Soteria paradigm shows, for example, the theoretical substance is not commonly found in the topics up for debate, but rather in the foundations *upon which* the debates take place. In a sense, the theoretical substance in certain institutions aforementioned is thereby presupposed, in other words actually serving as a prerequisite for the development of the institution in the first place.

These circumstances must be altered, for a necessary consequence of *a priori* theorising is the withdrawal from further discussion as to phenomena occurring within the walls of hermetic psychiatric institutions. Many 'progressive' institutions may have been built on solid foundations revolutionary for their time, yet they run the risk of coming to a standstill without a continuous and vehement debate — one which remains open to the public. Notions such as suicide, societal endurance, assignment of responsibilities, staff training, security guards, involuntary commitment, restraint and many more must be perpetually scrutinised. In Heidegger's words: "The real 'movement' of the sciences takes place in the revision of these basic concepts, a revision which is more or less radical and lucid with regard to itself. A science's level of development is determined by the extent to which it is *capable* of a crisis it its basic concepts. In these immanent crises of the sciences the relation of positive questioning to the matter in question becomes unstable."[50] Likewise, Nietzsche instructs us to remain vigil and open to change. His metaphors[51] are always processes, cycles, recurring patterns; never isolated historical events defined by a specific period of time.[52] Failure to remain open to change hinders further progression.[53] As a solution, I propose

---

[50] Martin Heidegger — Sein und Zeit. *Max Niemeyer Verlag Tübingen,* 2006, p. 9 — the english translation by Joan Stambaugh (State University of New York Press, Albany, 2010) has been used here

[51] Such as humanity's transition to an *Übermensch* if we are to overcome collective *ressentiment.* Nietzsche uses the term *ressentiment* to describe a poisonous desire for revenge, borne out of a sense of impotence, hence a frustrated resentment of the status quo. Such an imaginary revenge is undertaken by the slave class to overthrow the noble class in Nietzsche's 'On the Genealogy of Morality'

[52] See, for example, Nietzsche, F. (1887). "Zur Genealogie der Moral". *Goldman Verlag*

[53] I discuss a personal example of this in the entry 'Observations from an open circle', to be published on *isolatarium.org* (4/2019)

stronger incorporation of theoretical substance into everyday practise, whereby philosophy in particular may guide the continual revision of our basic concepts.

Recommended literature

A small selection for further reading has been provided. It is in no way complete. Please also refer to the extensive citations provided in the footnotes for further reading on specific topics.

Franco Basaglia (Hrsg.) — *Die negierte Institution oder Die Gemeinschaft der Ausgeschlossenen. Ein Experiment der psychiatrischen Klinik in Görz* (Suhrkamp Verlag, 1968)

Ludwig Binswanger — *Ausgewählte Aufsätze und Vorträge, 2 Bd.* (Bern, Francke Verlag, 1947/1955)

Matthew Broome et al. (Ed.)— *The Maudsley Reader in Phenomenological Psychiatry* (Cambridge University Press, 2012)

David G. Cooper — *Psychiatry and Anti-Psychiatry* (Tavistock Publications, 1967)

Klaus Dörner et al. (Hrsg.) — *Irren ist Menschlich* (Köln: Psychiatrie Verlag, 24. Auflage, 2017)

Maxwell Jones — *Social Psychiatry* (Tavistock Publications, 1952); and *Social Psychiatry in Practise. The Idea of the Therapeutic Community* (Penguin Books, 1968)

Stephan Käufer and Anthony Chemero — *Phenomenology: An Introduction* (Polity Press, 2015)

Karl-Peter Kisker — *Dialogik der Verrücktheit. Ein Versuch an den Grenzen der Anthropologie* (Martinus Nijhoff / Den Haag, 1970)

R. D. Laing — *The Divided Self* (Penguin Books, 2010, first published 1960)

Samuel Thoma — *Common Sense und Verrücktheit im Sozialen Raum* (Köln: Psychiatrie Verlag, 2018)