# Psychosis Is Not Illness but a Survival Strategy in Severe Stress: A Proposal for an Addition to a Phenomenological Point of View

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**Abstract**

*Phenomenology often looks at psychosis as a defined pathological state. In this paper, psychosis is not seen as a (pathological) state but as a way to respond in extreme stress. It is psychological functioning of the embodied and relational mind, and psychotic experience can be seen as one form of affective arousal among any other affects. Taken the point of views of Emmanuel Levinas and Mikhail Bakhtin about the primacy of living in responsive relationships, psychotic behavior is seen as emerging in relationships that do not guarantee adequate responses and thus the subject is imposed to isolate from social relationships and developing odd behavior.*

*If dialogical responses are guaranteed, recovery from psychotic behavior can occur. Some guidelines for such dialogues are given.*

**Key-Words***: Dialogism · Open dialogues · Psychosis · Embodied mind · Relational mind · Responsiveness*

Phenomenology has been focused on the first-person point of view. For me the human mind is not something owned by the subject, but it is a relational stream being best realized in multiactor settings [1]. Thus, experiences of the individual – as here the one having psychotic ones – are not seen as having been generated by the mind inside the person, but as a response to the actual interactional setting. Often in philosophical descriptions schizophrenia or psychosis is seen as a static variable of the subject including specific forms of observing, reasoning, and sensing that are seen illustrating the psychotic – or schizophrenic– perceptions. For instance, in his valuable study about the difficulties in applying phenomenology in psychiatry, Abettan [2] points out how most attempts have failed because of not adopting the core of phenomenology into the description of a psychiatric phenomenon.

But even he, in the end of the paper asks, "is phenomenology really able to approach pathological mental states?" [2, p. 538], thus including the idea of schizophrenia or psychosis being a pathological mental state. Within a medical frame it may be justified to look at psychosis as a pathology, but unfortunately the approach will not contribute with much possibilities for helping the person with psychotic experiences, because the person is seen as lacking some of the relevant psychological recourses in her/his life. In this paper a different point of view is chosen, which may be called a psychological or psychotherapeutic one. Mental functioning is seen as an embodied response taking place as an ongoing stream and not as static quality inside the mind of the subject. In phenomenology Merleau- Pounty describes the human existence as the bodily movements that create the point of view of the subject into the world [3]. Emmanuel Levinas [4] has an interest in the relational mind by seeing the Other as the one putting a demand to open the mind of the subject. In his work, responses become crucial also. In what follows, I will describe the essence of psychotic experiences and the dialogical psychotherapeutic practice. The paper is based on my own clinical experiences during the last 40 years and studies that I have conducted about the open dialogue approach and psychosis during the last 30 years, in which the approach has proved to be very successful; e.g., in the recent 19-year follow-up, it was found that psychotic patients treated in open dialogue had significantly better occupational outcomes, had used significantly fewer psychiatric services and psychosis medication as in the rest of Finland. In the treatment as usual the psychotic patients also had a higher mortality in illnesses [5].

From a dialogical perspective – in which being involved in responsive relationships is the core of human existence – psychosis is not regarded as a distinct set of categorical phenomena. All human beings are participating in responsive relationships. People experiencing psychotic problems are not qualitatively different from people who do not have psychotic experiences. Moncrieff and Leo [6] noted that there are no studies that had proved all psychotic patients having specific types of changes in their brains compared to the normal population. So, instead of looking at psychotic behavior as a deviance in the (brain)

structure, it can be seen as an active attempt of the embodied mind to survive extreme stress in one's life.

Psychotic experiences are affective reactions of the embodied mind. The persons having them are often not able to describe their emotional experiences in an explicit way, but instead the affective arousal felt in the body is overwhelming and becoming evident in a metaphoric way, referring to some concrete experience of the past, but taking a metaphoric form in the utterances [7] as a prenarrative quality of the psychotic experience [8, 9]. Hallucinations and delusions are part of experiences of people in stress without any psychiatric diagnosis [10].

As one element, psychotic experience involves difficulties in generating dialogue between the different voices of the mind, which are like fragmented pieces of experiences [11–13]. The lack of integration between these fragmented pieces of experience may result in extreme affective arousal being felt as alien to the person. Because being sensed as alien and something not seen before, they are felt to be outside of one's mind and consequently outside the control of the mind. The thing perceived is felt as a part of the observer and is always related to the context and relationships present. Psychotic perception seems to include two important aspects. Firstly, observations about the reality outside, where the observer often cannot make the distinction about the boundary between me and the other in some specific part of the perception field, which is often a very small part of the entire field of perception.

The second aspect concerns how the one perceiving the reality is sensing herself/himself in the process of perceiving. How do I make sense for the perceptions that may be psychotic? Psychotic experience – as any other human experiences – should be seen in the actual relationships, and the way it is responded to becomes important in increasing the empowerment of my own sensing of realities.

The dialogical point of view means respecting the Other without conditions, which means accepting the point of view being in the world that the one defined as psychotic is uttering. If the perceptions and the sensing of affects are accepted by the others present, stronger connections start to emerge between me and the one with whom I share my reality and consequently between me and the reality [14].

As Bertram P. Karon [15, 16] has noted, psychotic phenomena can be seen to be an expression, sometimes in behavior or actions, of embodied affective arousal that seems to be connected to terrifying experiences in one's life that have not been stored in explicit memory systems and which cannot therefore be formulated into coherent spoken narratives. These experiences do not have a language other than those of hallucinations and delusions, and in the dialogical approach the verbalization of such hallucinations or delusions may be helpful in beginning the process of constructing a spoken narrative of the terrifying experiences. They often include the terror of dying [16]. In this way death is present in the psychotic experience.

Levinas also points out that death is a part of the psychotic experiences [17].

Traumatic experiences as such – however – do not cause psychotic behavior in a linear way and thus are not reason for the psychosis, because people may tell of some traumatic incidents that could have happened decades before the actual situation. They are responses to the *current* affective experiences. Psychotic reactions could therefore be seen as attempts to make sense of one's experience and to cope with experiences that are so heavy that they

have made it impossible to construct a rational spoken narrative. Sometimes contemporary stressful situations that resemble the original terrifying situation in some respects can actualize the affects related to these earlier experiences.

One patient, for instance, became psychotic fearing that her husband was under the influence of drugs and would come and kill her. During the therapy meeting with the family, it was discovered that 16 years earlier she had been living with a man who was a heavy drug abuser.

While under the influence of drugs, he had repeatedly beaten her, a fact that she had never disclosed to anyone else. In their 2-year relationship, she really had been living under the threat of dying. Two months before her first psychotic episode, the man had phoned her for the first time in 16 years. She said that whilst hearing his voice, she could not say anything, but her body was shaking. Her body remembered the terror of dying she had had while living with the threat of violence of her former partner. The fear she felt towards her husband was a psychotic one; it was not him who was coming to kill her. At the same time, however, she was referring to something she really had experienced, that is, violence at the hands of her former partner.

Such experiences of severe victimization are not stored in the part of the memory of explicit language, but in the memory of the body by the sense of terror instilled at the time. Van der Kolk and his team [18, 19] have reported how the horrors of traumatic experiences may start to materialize in the form of flashbacks without the individual being aware of what these fragmented memory flashbacks relate to. They may also take the form of dissociative experiences, which often greatly resemble psychotic phenomena [20]: 60% of men and 69% of women had experiences of sexual or physical abuse in their childhood [21].

Karon and Vandenbos [16] see hallucinations as related to real incidents in the life of the person having such experiences including a terror of dying, and these can be understood as a response to real terrifying experiences. For instance, they describe a young man who started to speak Latin. Instead of seeing this as something random and meaningless, the therapist wondered if the young man had had an experience within the church. It transpired that he had been sexually abused by a priest when he was in the church choir.

As a starting point for a successful therapeutic relationship, Karon and Vandenbos [16] propose that the psychotherapist should take a strong position by supporting the patient in the defense against death, by promising that he/she won't let anyone harm the patient. To a dialogical point of view, their descriptions of the link between psychotic experiences and real life incidents are very helpful in contributing to our understanding of the vertical dialogues in psychotherapy (i.e., our relationship to our own past experiences). Unfortunately, their descriptions of horizontal (as family relationships at the present moment) polyphony are less helpful as they tend to accuse the mother – and the family – of the psychotic problems. Because of this assumption, they did not have adequate ways to collaborate with the family of the patient, but instead proposed that the family should be met by someone outside the therapeutic process, and the psychotherapist should not participate in family sessions.

## Psychotic Behavior as Embodied Action

There is some interesting evidence that suggests that psychotic behavior expresses a specific concrete embodied element [22–25]. Several important bodily responses have been observed in the context of hallucinations, as well as other forms of psychotic behavior [26]. With both psychotic hallucinations and dissociative reactions, one can experience strange bodily sensations without a visible source. This can include, for example, a smell, or unexplained pain in some body part. The stressful current life situation activates previous similar affective memories in the body. When dealing with the huge affective arousal, our embodied mind generates hallucinations or delusions instead of a clear narrative memory of our experiences.

The body talks through metaphor, "narrating" and enacting the person's story. When another person first hears the content of hallucinations, they may seem impossible to follow and understand, because the person is experiencing real voices and events and experiences as if coming from outside of him/her in the present. When the reality of the person's experience is not accepted by the professionals present, this often results in the person feeling less in control of his/her experiences, along with a sense of diminished agency in their capacity to communicate their experience [8, 27, 28].

Sometimes psychotic experiences and forms of communication can take over all the stories and other experiences in a person's life, and other more constructive voices in his/her life become silenced. In addition, much of contemporary psychiatric discourse, and the practices associated with it, negatively affects the diagnosed person's agency, by stating that psychosis is a product of a brain disorder which has nothing to do with the real life of the subject. These types of comment further limit the scope of his or her communication with others and thereby constrain possibilities for beneficial self-understanding and action [29, 30].

As a fruitful hypothesis for helping people in their psychotic crises, perhaps we could see hallucinations and delusions and consequently psychotic behavior as one form of affect. Affects in general can be considered our body's reaction and an attempt to recover the homeostasis that has been threatened by some incident outside or inside the body. Emotions – such as feeling anxious or having panic reactions or being in a depressed mood – belong to life as natural components of different circumstances.

When extreme, they become problematic and prohibit and inhibit constructive responses to the stressors in our everyday lives. We may then be diagnosed as suffering from anxiety or panic disorder or depression. However, such phenomena arise in a way similar to hallucinations and delusions in that hallucinations are also reactions of our embodied mind to extreme stress – usually there are several stressors at the same time [16]. For instance, a person may hear the voice of the loved one who died suddenly.

It is not difficult for this person to understand such an experience as their emotions trying to re-establish homeostasis and save him/her from the pain of loss. But at some point, if stress continues to increase, this person may lose contact with reality testing and their understanding of the emotional experiences in relation to their life, and this can develop into a psychotic experience. He/she experiences the voice as existing in both his/her inner *and* outer life and by then he/she will have lost the capacity for making sense of them, no longer seeing subjective experiences as potentially symbolic expressions of some earlier incident in their lives.

Hallucinations and delusions are expressions of our human emotional system adjusting to extreme stress and not symptoms of some biological illness, although there surely exist biological correlates of these emotional reactions.

From this perspective, a major aim in therapy is to help the person to develop a fuller understanding of their reactions and to see how they are connected to their current and past experiences, like the ways in which, with or without therapy, we work to understand the affective arousal and emotions that lead to depression or panic attacks.

Psychosis or schizophrenia are not psychopathological states. Instead, generating psychotic responses under an extreme stress is a sign of a functioning mind that finds ways for defending itself and re-establishing the homeostasis of the organ.

## Generating Dialogue Is the Response to Psychotic Experiences

Emmanuel Levinas [4, 30, 31] sees responsiveness as an unescapable part of human life. For him, the Other is always there before me and demanding to be responded

to. I cannot escape the demand of responding to the Other. Perhaps the psychotic patient finds herself in this type of situation. Within an extreme experience of embodied stress and affective arousal, she must respond to the demands of the Others in her life. In the extreme stress, the responses may become unfortunate. One aim often seems to be trying to have distance to the Others close to her, because they are becoming too demanding, felt to be too close to her. When disconnecting from others, a way is opened to become isolated and the isolation becomes one form of response to the Others, which often make things worse. Without the adequate response from the Other, she herself cannot function adequately and may start to generate a form of behavior that may be seen as strange, like speaking to herself, shouting to herself, walking strangely. These forms of behavior are part of the responsive processes, not signs of illness. The crucial point here is the response from the Others. For Mikhail Bakhtin [32], the Other is in a different position than for Levinas. Whereas Levinas sees the Other as the first one, Bakhtin sees the Other as being for me and making me human by her responses. Following this, we cannot see any human forms of behavior in isolation as only behavior of the single subject, but always as a part of the responsive relational context. The human mind is relational and dialogical [33]. If the response of the Other is adequate, it helps open the access to more adequate forms of behavior and being an author of her own life.

We need dialogue to help the one with psychotic experiences. In open dialogue meetings, the starting point is the way how each participant has seen the problem. Therapists – who most often work as a team – adapt their way of speaking according to the unique needs of every patient and their family. Every conversation creates a new language [33, 34]. Each person present speaks in their own voices, which need to be respected. Listening becomes more important than the manner of interviewing [34]. In the case of a psychotic patient, it is important to accept the psychotic hallucinations or delusions of the patient as one voice amongst others. These are not challenged, but the patient is encouraged to say more about the experiences.

The function of open dialogue is to allow the participants to construct a new language to express and discuss together difficult events in their lives. These events can be of any kind and could have happened at any time, and the aim in the dialogue is not to find out the

exact original experiences. Whatever the former experiences may be, it is important to take hallucinations seriously and not to challenge the patient's reality during the crisis, especially in the beginning phase of treatment. Instead, the therapist could ask: "Did I hear you correctly when you said that you have control of your neighbor's thoughts? Could you tell me more about that?" The other network members in the meetings could then be asked: "What do others think of this? How do you understand what M is saying?" The purpose of such questioning is to allow different voices to be heard concerning the themes under discussion, including the psychotic experience. In this "restoration of trust in soothing interpersonal emotional regulation makes it possible to allow others to affect us in dialogical relationships" [15, 35].

Once a young man asked for meetings after being very disappointed by the family meetings they had had when he was hospitalized because of psychotic episodes. He said his parents were willing to come to the meeting although they had separated 20 years ago and did not have any contact with each other. In the first meeting we met with him, his younger brother and their mother, in the second with the two children and their father, and in the third with all four together. The third meeting was loaded with extreme tension. The younger brother first said that this meeting should have taken place 20 years ago, and after a while the mother said the same. Difficult issues were taken up from family life together in the past, such as the problems the parents had dealing with each other and in taking care of the children when they were small. The father was very rigid in his attitude in the meeting – and even in the way he was sitting – but he listened to the criticism of the children.

When asked what he thought about their critical comments he said that he felt bad and that it was not his intention to harm his children in any way. Towards the end of the meeting the atmosphere became more relaxed, and the family even made some jokes about their history.

When asked at the end of the meeting how they had liked the dialogue, all of them said that they were surprised that the discussion was so different compared to the one they had in the hospital, where the doctor in charge of the meeting seemed to have the aim of finding out how mad the son was and how disturbed the entire family was. In the dialogical meeting they felt very different in the way that everyone was heard and respected, even if they each had different opinions. This was the key difference from the other approach, a comment that they repeated at the end of every meeting that we had over one and a half years.

In the meetings, patients seem to start to speak in a psychotic way when the most sensitive and essential themes concerning the psychosis are being discussed.

Perhaps at this point something of the experiences without words are touched upon, and it is important that therapists pay attention to what is happening at that very moment. One can ask, for instance, "What did I say wrong, when you started to speak about that?" Or "Wait a moment; what were we discussing when M started to speak about how the voices have control over him?" In a way, the "reason" for psychotic behavior can often be seen in the conversation at such crucial points.

In general, the team allows the patient and his or her network to take the lead in determining the content in meetings. The main task for team members is to ensure a response to the utterances of family members in a dialogical way in order to promote new understandings among the different participants [29, 36, 37]. One way to respond is to

initiate reflective conversations [38] among team members. It can start the team member asking kindly for permission to do this: “I wonder if you could wait a moment so that we might discuss what we have started to think about? Afterwards we will ask for your comments on what we have said.” Usually the family and the rest of the social network listen very carefully to what the professionals say about their problems.

## Some Simple Guidelines for Dialogues in Psychotic Experiences

In dialogical practice the main aim of the meeting is to generate dialogue both between the participants and with their inner dialogues. This could involve, for example, pointing out that it is natural to have different thoughts about the issue that is being discussed – one does not need to have only one opinion. In this way reflectivity is increased, which in turn makes it more possible for everyone to evaluate different experiences and different voices and hear more about how other family members have felt about the issues being discussed. Often there are surprises for the family members because, for example, they may hear how children in the family experienced issues earlier in their childhood very differently from the way the parents did. In the dialogue family members may become more open to both utter their own experiences and if taken seriously and heard they will start to listen to each other.

If this type of openness to other voices is increased, it may consequently increase one’s own authorship in life after realizing what are his/her own points of view in relation to others. In psychotic crises the task is the same, but there are some specific challenges to be aware of.

A crucial aspect of achieving genuine dialogues is by respecting the other without conditions [37], something that is often challenging in crisis situations, but especially when having discussions with someone with psychotic experiences.

In optimal dialogues we do not challenge the life view of the other, but rather encourage him or her to help us understand more about their way of seeing their life and to listen to the way others experience the same life issues.

In dialogical practices there is no place for reality orientation by saying to the patients that “the things you are speaking are your illness, and not reality”.

The elements discussed in the following have especial importance in psychotic crises.

### *Having a Relational Focus Throughout*

The relational focus is concerned with both horizontal and vertical dialogues. It includes *horizontal voices*, i.e. the communication between those who are present in the meeting. The main challenge is to generate dialogues in which all participants are equally respected and included in the dialogue, supporting them to share information and opinions about their lives, whilst at the same time listening and reflecting continually on what all participants are saying. This does not mean that everyone should speak as much as any other – instead therapists should assist everyone in their own unique way to be included and involved in the dialogue. In an acute crisis, the meeting is often started by listening carefully to the one having psychotic experiences whilst at the same time being sensitive to the ways in which other family members react while listening to the stories that every now and then include psychotic utterances. When asking for the ideas of others about what had previously been said, it is best to emphasize the affective experiences of the one who was speaking instead

of going into a debate as to whether psychotic experiences are “real” or not. In this way the team can enhance connections between family members and reduce the mutual isolation between the patient and other family members; it has often been extremely difficult for the latter to accept the reality of the one speaking in a psychotic way.

Another domain of the polyphony of voices are the *vertical voices – the “inner voices”* – of every participant, and these should also be encouraged. Those experiencing psychosis do not only have “psychotic” speech, but also communicate in more everyday ways about their life.

Both forms of speech should be respected and listened to. Other family members are in a similar position of having multiple feelings. Even if they often have quite frustrating experiences and express criticism towards the patient, they always also show care and concern about him/her.

Furthermore, family members should be encouraged to speak of other aspects of their own life, not only those related to the crisis or the patient.

### *Respecting the Psychotic Experience without Conditions*

In psychotic crises, this mainly means not challenging the psychotic experience, but instead being curious about what was said.

One of the basic aspects of dialogical practice is to enable the speaker to hear what he/she is saying to him/herself, through the accepting response of team members. It is most unlikely that the person with psychotic experiences can start to reflect about his/her own experiences if his/her point of view is rejected from the very beginning. When someone starts to speak in a psychotic way it may mean that, at that very point in time, he/she is speaking about the most difficult/traumatic experiences in his/her life but does not have any other words for these being only able to express this in this psychotic way. If we start to “reality orientate” people experiencing psychosis, we may increase the risk that it does not become possible for them to begin to expand on their ideas as to what has happened in their lives, including painful experiences. By fully accepting the utterances of the other, we thereby encourage her/him to speak more about hallucinations or delusions. In acute crises most patients think their hallucinatory voices are real experiences, and it is especially important at this moment to encourage them to go further in their reasoning by asking, e.g. “wait a moment, did I hear you correctly when I heard you saying that you had some strange thoughts? Can you help us understand more about that? When did all this start? When does it happen? Is it all day or some part of the day?” These questions are examples of how we can include unusual experiences in everyday conversation, instead of defining such experiences as pathological or unacceptable.

Accepting the other in his/her psychotic utterances is a challenging practice, which aims to generate a feeling of being recognized and taken seriously. Later, in the course of the recovery process, the patient may come to think that the hallucinatory voices that she still hears are not happening in external reality but are part of her inner experiences and thus are no longer psychotic [39]. At this point the nature of our dialogue about the voices can be quite different compared to the situation in an acute crisis. For example, one female client in psychotherapy started to realize that the voice of her aunt that she had been hearing was not coming from external reality but gave words for some fears that she had in relation to

her aunt. During our therapy we both started to realize that this may be related to the fact that her aunt does not always accept her religious orientation, and the patient is no longer willing to go on with the debate with her aunt about this issue.

Overall in the dialogue, regardless of whether it is an acute crisis or a later stage in the process, it is essential to have the attitude that our dialogues are with human beings and not with psychotic patients. If our orientation is that we are talking with a patient, we can too easily become focused on searching for the pathological aspects of his/her experience, whereas the aim of dialogical practice is to mobilize the positive resources of our clients – both the person at the center of concern and his/her family members.

### *Emphasizing Feelings and Affective Aspects of the Stories Told*

The patient may speak about extreme stories that could scare both the therapists and the family members present. These may include auditory hallucinations in which there is a threatening voice commanding the person to do something violent, or they may include some scary visual hallucinations. Strong paranoid belief systems may also put the clinicians in challenging situations when the patient is giving detailed evidence about what is happening in their world to justify his/her fixed beliefs. A patient may insist on an answer from the clinicians as to whether they share his beliefs. Getting into a debate as to whether the experiences are real or not is most unlikely to open ways into more dialogical deliberations about the person's life and about the role of the belief in it. In the dialogue in psychotic crises, it may be even more important to focus on the emotional experience that the patient is having when he is telling us, for example, about the persecutors that are after him. This can be done in a simple way, for instance saying, "it sounds like you are in a situation in which you really feel very distressed," or you could instead say something like "it really sounds like a scary situation for you. I realize that this has been very hard for you – could you tell me how you feel when you are being threatened?" With these kinds of comments, I have sometimes succeeded in finding a way to a more open space to reflect about the person's life, including aspects unrelated to the threatening psychotic experiences.

### *A Preference to Being Present in the Here and Now*

In dialogical practice this is one of the main overall guiding ideas. Instead of focusing primarily on the narratives about the life of the clients, we concentrate more on what is said in the present moment and to how the responses to what is said mutually affect the experience of the participants in the meeting. Any experiences that have taken place before the meeting can be discussed, with the focus being on the key emotions which are felt and expressed – the actual event may become secondary.

In psychotic crises there are additional elements that emphasize the importance of this way of working. Whilst speaking about something that we clinicians may think of as psychotic experiences, the patients may, for the first time ever, be speaking of the most extreme experiences in his/her life that until now they did not have any words to speak about. In our initial contact with a network during a crisis there is a window of opportunity to discuss delusional thoughts; the challenge for clinicians is how to be present in a way that supports further deliberation about the delusion(s). This depends greatly on the way in which we hear the stories that are shared and how we respond to them at these moments. Hallucinations

will probably appear at the most emotionally loaded point in the telling of the story – and at that moment it may well not be possible to find words to speak about the core experience. In clinical practice, and from the studies I have conducted [10], I have learned to follow a guiding idea of stopping everything else in the dialogue and focusing on what has just been said at the moment of appearance of the "psychotic" communication.

## Concluding Remarks

In this paper the aim has been to introduce a nonpathologizing view of psychotic problems. The open dialogue approach described has proved to be an effective way for supporting psychotic patients to return to active social life [5]. The concrete clinical practice – the way that therapists speak with the psychotic patient – seems to be very much the same in different effective psychotherapeutic methods. In cognitive behavioral therapy also one of the basic assumptions is normalizing the psychotic behavior [40]. In the same way as said in this paper, they say that "paranoid thoughts are an appropriate strategy that can, in particular circumstances, become excessive, just like anxious thoughts" [40, p. 407]. It seems to be the concrete relationship with the patient and the family that helps clinicians choose a respecting attitude to the experiences of the patient and the family. Phenomenology with the emphasis on the first-person experience can enhance the psychotherapeutic practice. However, so far, a lot of the philosophical interest has been focusing on the pathological side of the psychotic experience by analyzing the differences to normal perceptions.

In addition, the aim has been to look at psychotic behavior in the relational context. Psychotic problems are not primarily problems inside the individual, but instead always responses to the actual stressful situation in one's life within the relationships. Including the families and other relevant social network is the cornerstone of open dialogues. In phenomenology not so much interest has been focused on the family and on the relational issues. Including the family also emphasizes the importance of looking at the problematic behavior in the everyday life context and within the relationships, in which the patient is living. Hopefully in the future phenomenology would have more interest on this side of the road and thus contribute more on developing the respectful clinical practices.

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