

Philosophical Midwifery: A Way Of Understanding And Treatment Of The Problem Of Relapse And Recidivism

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Relapse and recidivism have been chronic problems in mental health and the criminal justice system. This paper proposes an application of philosophical midwifery (PM) to the problem of relapse and recidivism in mentally ill cases. First, we will discuss the nature of recidivism and relapse, the kind of problem it is, and the common ways of understanding and treating relapse and recidivism. Next, we will discuss the application of a modification of PM as it applies to mentally ill cases to identify the beliefs that lead to relapse, recidivism and re-hospitalisation. Lastly, we will discuss how it is possible to bring some patients to learn to identify and to explore the false beliefs about themselves that are the underlying causes of their repeated problematic behaviour. Consequently, for those patients who are able to participate in philosophical midwifery, they become more self-reflective, more responsible for their actions and are more motivated to pursue their own goals.

The term recidivism, from a psychological view, normally, is applied to those individuals who have a chronic tendency or repetition of criminal or antisocial patterns of behaviours (Wolman, 1973). A similar chronic tendency or repetition of behaviours can describe those who are re-hospitalised in psychiatric facilities, those who return to their addictive behaviours, or the mentally ill who re-offend (Wolman, 1973; Simpson, Lehman and Sells, 1986b). Relapse from a psychological view, is a 'recurrence of symptoms after cure or period of improvement'. Recidivism in its general use is defined as repeated or habitual relapse. Relapse is defined as a falling back into a former state. Whether from a psychological view or its general definition relapse and recidivism have the common theme of returning to a former condition or behaviour. We often think of relapse or recidivism as cyclical behaviour, but is it? When we review the definition of the terms 'cycle' or 'cyclical behaviour' we find different types. We can talk about cycles in terms of time or when certain events repeat themselves at

certain intervals; we can talk about cycles as changing states that occur in a sequence and return to its original or former state; we can describe cycles as a series of periodic occurrences. What appears common of cyclical behaviour is that it has a structure, a defined order that goes through stages or steps at regular intervals, which are predictable, and thereby makes it understandable.

Relapse and recidivism appear to have the rudimentary features of a cycle as a series of behaviours that appear to repeat former behaviours, but there is no indication that such behaviours occur at set intervals, or repeat defined stages or steps, or that they go through a set of ordered changes and return to a former original state, and thus it does not have the potential of being predictable. Given what is known of recidivistic behaviour we can describe it as an appearance of cyclical behaviour that habitually returns to a former behaviour without predictability or understanding.

Presently, the majority of theories influenced by the medical model explain the causes of repetitive behaviour organicistically (Sadock and Sadock, 2000). Some assume biochemical or genetic causes, others assume relapse, recidivism and addictive behaviours are stimulated from pathogenic environments and yet others believe the origins can be found in unconscious factors. There are some from the non-scientific community who view such behaviours are due to malevolent natures or souls. The more hideous the behaviour the more vocal are those who say the cause is due to evil natures.

Accordingly, treatment or external controls of these behaviours is determined and governed by the assumed causes (Sadock and Sadock, 2000). Medications are given to correct an assumed biochemical imbalance; positive behavioural interventions and strategies reward what is assumed to have been stimulated by unrewarding negative conditions; education and social skills training

provide repeat offenders and re-hospitalised patients with what many assume to be a lack of knowledge and skills due to poor environmental conditions. Others who assume causes lie in unresolved conflicts of early childhood attempt to help patients work through these conflicts. And still others believe that such behaviours deserve punishment. These latter believe that suffering and negative consequences will create an aversion to repeating the behaviours. These treatments and strategies have varying degrees of success but there continue to be large numbers of individuals for whom these programmes have been ineffective in preventing relapse, re-hospitalisation and/or re-offending (Robertson and Gunn, 1987; State of California, 1997).

In recent years there has been significant interest in cognitive psychology and the cognitive therapies. These methods of treatment have introduced to the scientific community the role irrational beliefs play in one's actions, behaviours and life (Dobson, 2001). In review of the modern cognitive therapies (Dobson, 2001), it is evident that they assume and use behavioural principles to treat cognitions and schemas. Most of the treatments of the manifested irrational cognitions are treated by techniques applied to the 'here and now'. If any of the cognitive therapies review past childhood influences there is no clear methodology to identify past events with the present cognitions nor a methodology to identify the underlying belief system that produced the present day irrational thoughts and behaviours, nor are there specific methods to explore the meaning and function of the identified false beliefs and why it continues to manifest in the present.

I have presented general profiles, definitions, common assumptions and methods of treatment related to the problem of relapse and recidivism. This paper introduces the hypothesis that the theory and methodology of Philosophical Midwifery (PM) (Grimes and Uliana, 1998) and its clinical application Grimes Dialectical Rational Psychotherapy (GDRP) offers a way of bringing to birth and understanding through dialogue the false beliefs that underlie the plaguing problem of relapse and recidivism in the criminal and severely mentally ill population. This paper will present a summary of PM's theory and method and describe PM/GDRP as it applies to case examples in the severely mentally ill population. Philosophical Midwifery is a form of analysis adapted from Socratic midwifery by Pierre Grimes,

and applied to the belief formation called the pathologos, or sick reasoning (Grimes and Uliana, 1998). Uliana (1997) extended and adapted Philosophical Midwifery's dialectical method to the pathologos that the severely mentally ill manifest and in particular to the pathologos manifestations in repeated problematic behaviour among this population. Grimes and Uliana (1998) describe the principles of philosophical midwifery have been developed, primarily, for those individuals who are able to state their problems in their pursuit of personal excellence. Whereas Grimes Dialectical Rational Psychotherapy is an adaptation of PM's principles as it applies to those who cannot state their problem, or have such anxiety they are unable to set goals (Grimes and Uliana, 1998).

There are two major assumptions that this analysis brings to the psychological and psychiatric world and to the prevailing problem of relapse and recidivism. An assumption of Philosophical Midwifery/GDRP is that individuals pursue those goals that they believe will achieve their good. Further, PM claims that people are inherently rational and that their behaviour proceeds from premises or beliefs some of which have been articulated while others have not, yet in either case it can be seen that behaviour is understandable. Accordingly, PM/GDRP assumes psychological problems are understandable because they have a structure or morphology. Each problem is assumed to have a goal or purpose, specific steps that repeat in cyclical form with emotional highs and lows, a specific function within the family and a history with identifiable patterns.

PM/GDRP (Grimes and Uliana, 1998) assumes that fundamental to the formation of problems is an underlying, unsuspected, unquestioned, non-verbalised false belief called the pathologos (sick reasoning), whose continued presence repeatedly causes suffering and chaos in one's life. The acceptance of these false beliefs occurs when authority figures present themselves with an appearance of caring, loving and knowing, and the scenes, situations or conditions in which the pathologos was transmitted was so structured that no alternative explanation was believable. The consequences or confirmation of the acceptance of the pathologos manifests in unproductive attitudes, emotions and behaviours including repeated behaviours. Understanding the particular conditions

that led to the acceptance of these beliefs and the function these beliefs have in the relationship with the parents or guardian is paramount in Philosophical Midwifery/GDRP.

PM's method of dialectic (Grimes and Uliana, 1998; Grimes, 1987) brings an understanding that repeated problematic behaviours are based on false beliefs that were accepted as true because those authority figures in early childhood appeared so caring and loving. It is believed by the child that to reject that appearance would be tantamount to rejecting their parents rather than an appearance. The appearance is a departure from the parent's usual way of being and it is in sharp contrast to what the child had accepted as a model for their behaviour. The power of this appearance on a young child's mind puts into question his/her own experience. A fear or threat of exile or rejection from the family appearance of love and care leads the child to conclude falsely about oneself and one's reality in a wordless conclusion - one not put into words. These false beliefs are not reflected upon or voiced, yet the child functions from them as if they were obviously true. And so, the child is governed by them. PM then explores why the acceptance of false beliefs continues into the present. The person must then return to his/her goal to test the insights gained through PM dialogue sessions and also to identify any other beliefs that emerge when pursuing one's goal.

It is through stressing the order of questioning, that the subject is drawn to explore incidents of problematic behaviour and identify the underlying false beliefs. The subject can then anticipate the direction of the dialogue and assist in the delivery of the problem. The method itself becomes a map to chart the direction of the dialogue. The method itself brings out the data from which the subject can puzzle out the meaning of and the answers to his/her problem. Therefore, the midwife has no need to interpret, offer advice, suggest techniques or appear as an authority on the meaning of what the subject reveals. PM/GDRP does not interpret for the individual either by way of a therapist's analysis, advice or prescription of restructuring techniques to control, avoid, or replace negative thoughts. Hence, as a non-interpretative system, it assumes that any criticism, recourse to interpretative analysis, inference, technique or strategy or any intervention other than questions that follow the natural stages of the dialectic (Grimes and Uliana, 1998) deprives the individual of valuable insights as they pursue

understanding. Its goal is to understand and discover the reason and function for accepting unquestioned beliefs called the pathologos - false beliefs that are passed from generation to generation and that define the family belief structures and the roles of its members.

In addition to the pathologos' cyclical nature, and its unsuspected presence, it is surfaced and challenged when a person decides to mature and grow taking on personally meaningful goals (Grimes, 1987; and Grimes and Uliana, 1998). Seeking to attain one's personally meaningful goals inevitably goes against the pathologos' own goals - goals that demand subservience to the learned family beliefs. For the pathologos is irreconcilable with one's meaningful goals. When one strives towards one's own important and personally meaningful goals, it is at these times that the pathologos, the false beliefs, demand obedience. At these times, one is confronted with the choice of being loyal to the pathologos or to a new way of viewing the world. When given these challenges a person often remains loyal to the pathologos and thus returns to a former state. But the person does not know that to which he/she is obedient, for the pathologos remains invisible, undetected, until, through careful exploration and questioning one discovers that one has been repeatedly functioning, living under false beliefs that have robbed oneself of more meaningful states of mind and ways of being. When one goes further and examines where and when one has accepted false beliefs and why one has been loyal to them, one then realises the power of the pathologos. Finally, when one tests one's insights in one's experience the power of the pathologos diminishes and the individual moves towards human excellence. But, if one remains loyal to the pathologos, one's behaviours remain on the level of habits.

When we apply PM/GDRP principles to the severely mentally ill populations (Uliana, 1997; Grimes and Uliana, 1989), we find that the individuals are not able to meet the initial conditions or the first stages of the dialectic (Grimes and Uliana, 1998). In this first stage, a person must first recognise that he/she has a problem; it must be stated and described in what way and why it is a problem - namely that the person has beliefs which interpret his/her way of being and which repeatedly block the achievement of one's goals. In essence, the person comes to recognise that the nature of a problem is due to false beliefs that have become personal philosophies or personal ways

of being and viewing the world that function to block and undermine personally meaningful goals and excellence.

Due to a great deal of anger, anxiety and denial many mentally ill individuals are unable to state or admit to a problem. Thus, modifications are necessary. Sometimes, when working with those who deny problems or cannot admit to a problem, it requires providing a structure where artificial goals are designed so that they can begin to focus on their patterns of attitudes and thoughts. The intention is that they will recognise or discover they have problems and eventually set their own goals. Since PM/GDRP assumes that a person's problem will exhibit itself, although not as intensely, even while working towards practical goals, it was possible to set such practical goals as grooming on a regular basis, attending groups on time, concentrating in groups or following the routine of the hospital.

To help the patient focus on his/her states of mind, I found visual aides such as drawing a picture of a person climbing a staircase as someone working towards a goal (Grimes, videotaped lecture, 1997). The reason for the staircase is that it helps represent that there are steps towards goals. And, as the patient is pictured climbing the staircase, the patient is also pictured encountering obstacles. Each obstacle is a cycle which begins when a person moves away from his/her goal and enters what PM/GDRP calls the doorway into one's problem (Grimes, 1987). The elements of this doorway manifest in states of mind expressed in common language but which have private meanings particular to each individual.

To bring them to recognise they have a problem, the individuals must choose a realisable goal within the hospital. When I meet with them individually, each is asked what their goal is, and whether they moved away from their goals at any time, and if so can they describe what they recall they told themselves that decided they didn't need to continue their goal. I ask the patients to recall what thoughts occurred to them that convinced them they didn't need to groom or attend class etc.

Given their level of anxiety, the majority of these individuals spend most of the session focusing on the content that moves them away from their goal(s). For others who are able, they are encouraged to reflect on the

stages that follow after they pass through the doorway of the problem and chart the cycle of steps that include thoughts feelings behaviours until they have completed the steps of their cycle and can return to their goal. For these latter individuals, they are better able to see that their problem has a cyclical nature that goes through steps and different states of mind that manifest in behaviours. To whatever degree they are able to engage in this practice, if they allow themselves to explore their problematic behaviours each time they occur, then they are rewarded in discovering that there is a repeated state of mind underlying their problematic behaviours, and that this state of mind repeatedly emerges when the person is seeking to achieve meaningful goals.

If they are able, they can go on to discover that the nature of their problems are false beliefs that 'trigger' or precipitate their particular cycle that has caused chaos in their lives. Unfortunately, many of these individuals do not reach the level of learning why they accepted these beliefs and why they continue to believe them as would be found in those practising PM, purely. But, to the degree they are able to recognise the patterns in their states of mind, brings about a realisation that their problems are their responsibility and can be understood.

Identifying the state of mind that precedes the manifestation of the problem, learning the steps of one's cycle, exploring and discovering the meaning and function of the cycle is the procedure that allows the patient to anticipate the beginning of his/her cycle and thus the moment of possible relapse and repeated problematic behaviour. That is, the patient recognises that they entered into a cycle that has particular familiar repeated steps or stages once they move away from their goal and accept false beliefs about themselves. If patients can reach this stage in treatment where they see their problem has a structure, follows particular stages that have repeated states of mind, then they begin to realise certain of their states of mind repeat themselves, and therefore can conclude that their behaviour follows a predictable pattern or model.

As another aide to help their reflections, each is required to carry a notebook in which they make notes of their states of mind, when they become aware that they have moved away from their goals or when others have noticed for them. If they cannot do this, then I keep notes of each session and bring them for their review to help them remember. If it's a voice that intrudes, or an urge for drugs, or a sudden elevated mood or when they have urges to

hurt themselves or hurt others, they are encouraged to reflect on any thoughts, feelings or attitudes they may have had before the event. In this way they are brought to discover repeated patterns of thoughts and feelings before each event. If they follow these steps they then recognise that the times they have a particular state of mind, it often leads them to act out a cycle of feelings, thoughts and behaviours. Cognitive Behavioural Therapies (CBT) may reach this point and begin to instruct the individual or challenge the logical inconsistencies of these various ways of thinking, or introduce an alternative approach or way of thinking such as making a list of the automatic negative thinking and identifying and practising rational responses, or providing evidence against the negative thinking or replace negative or irrational thinking with positive and rational thoughts (Dobson, 2001; Steen, 2001; Greenberger and Padesky, 1995; Linehan, 1993; Burns, 1980). The focus in treatment is to reduce, remove, replace and avoid symptoms of thinking errors or negative cognitions. Some CBT methods acknowledge cyclical behaviours. For example there is an assault cycle (Mussack and Stickrod, 2000) that is required for some clients/patients/offenders to explain their behaviours in terms of that model. And while certain approaches using the assault cycle assume a childhood trauma relates to the behaviours, they do not have step-by-step procedures to identify the underlying belief systems that reveal why the false beliefs were accepted and why they have continued into the present. Further, instead of correcting the false belief, or confronting its inconsistencies or having the patient practice rational responses, PM/GDRP offers a methodology to identify and understand the function of the underlying beliefs in terms of the data itself, that is the patient's particular language which carries private meanings. Understanding the causes of the false beliefs and their function is essential.

Once the patient begins to realise that a similar state of mind, or language, repeatedly emerges when striving for meaningful goals they chose to accomplish within the hospital, the patient is then asked to explore the states of mind that led to re-hospitalisation. For those who are able to consider these questions, they realise that they experienced a similar state of mind before re-hospitalisation as they experienced as blocks to achieving their goals while in the hospital.

From this realisation, for those who are able, they find they can learn from the problems they experience in the hospital. Learning from these in-hospital experiences is unique. For the most part, modern treatment focuses on reducing or eliminating symptoms and problematic behaviour and rewarding positive behaviours with the assumption that no learning can take place if one explores the symptoms and behaviours themselves for they are assumed and treated as irrational.

Obviously, some individuals will turn away from this way of analysis and continue to remain loyal to their pathologos, but for those who challenge themselves, they begin to realise that their delusions, their voices, etc. interfere with their goals. They are engaging in self-reflection and studying what a part of themselves is doing to another part. In some way, they are reflecting on a false view of themselves that has perpetuated to cause them and others suffering and chaos. This is at first a shock, because they have truly lived out all their false beliefs as if they are all real and themselves - their voices, their anger, their negative behaviours, the inevitability of it all. But, when they discover a repeated state of mind or belief occurs before or leads to problematic behaviour, they discover their own thoughts - false beliefs contribute to their difficulties and not outside factors. Obviously, for individuals who, initially, are in denial of any problems and too anxious to reflect on themselves, to be brought to this level is certainly significant. It often reduces the level of paranoia for some patients.

Let's consider two case examples where PM/GDRP principles were applied to the problem of repeated problematic behaviour found in re-hospitalisation, relapse and/or recidivism. Each of the individuals that are described below has had an extensive history of repeated problematic behaviour and several hospitalisations. Both also had repeated arrests for misdemeanour criminal behaviour and both repeated their problematic behaviour while hospitalised. Each person would meet in individual session. Each was asked to explore the state of mind preceding the manifestation of their symptoms or problem behaviour.

The first case, Jane, was a middle-aged woman who had been in the psychiatric hospital for a year. She had jumped from a wire that stretched between two houses. She believed that she could walk across this wire and if she could, it would prove whether she

loved God enough. She was diagnosed with a Bipolar disorder. This disorder is commonly treated through medications and has significant empirical data to indicate biological correlates. It is even thought that it may have a genetic cause. Since it is considered an organic disease other kinds of treatment are considered superficial. In this case, she was in such denial of any problems that she would state that she would not take her medications even following discharge. I scheduled weekly appointments over the year that she was on my hospital unit and decided to focus in-depth on her state of mind and the events of each of the past incidences that occurred that led to at least thirteen psychiatric hospitalisations.

Reviewing these incidents, again and again, through the dialectic (Grimes 1994) revealed that similar states of mind occurred prior to her hospitalisations. Note that this person would go without medications sometimes for a year or two before she would be re-hospitalised. Stopping her medications (often considered a reason for symptoms returning) did not appear to be the only factor, in this case, for her symptoms returning.

As with each of these cases, it must be noted that Jane had great difficulty staying focused. What PM/GDRP (Grimes and Uliana, 1998) calls *counterattacks* commonly occur and are manifested as excuses or being easily distracted or more commonly a failure to remember. The degree and frequency of these *counterattacks* obviously slows any progress and makes each session as though one is starting anew. *Counterattacks* are those thoughts that support the pathologos and challenge growth. The pathologos itself survives through the function of amnesia. It is this element that prevents reflection on the pathologos structure and patterns. Counterattacks are also false beliefs and can be the focus of treatment as well.

We find such phenomena in ourselves. Many times we recognise we have experienced a similar problem or repeat similar states of mind, but we have certain beliefs that convince us that reflection upon the problem is not necessary or that it is not as similar as it appears to something before. Mentally ill patients experience similar dynamics only more dramatically and intensely. Access to memories is strongly controlled by the pathologos. But for those who are able to recall states of mind, they become more

aware of them as patterns. In many cases the individuals are convinced that their behaviours are only due to organic causes, which makes focusing on patterns of thoughts unnecessary as long as they take their medications. As a result, memories of personal experiences are frequently avoided and not discussed; consequently, false beliefs remain unquestioned.

Jane was in denial of having any problems. She was asked to discuss the events surrounding her hospitalisation. She recalled that before her manic episodes, she often would do something she felt proud of and had done well, and then someone whom she respected would ignore or destroy her good works. She concluded that she had to 'just put up with it'. But there were times when her rage forced her to walk away from these situations. At these times her manic symptoms would appear where she would then endanger herself, all the while denying to herself she was engaging in endangering behaviours. She would eventually be re-hospitalised.

After several sessions, Jane recalled that her thought, 'just put up with it' was reflected in each of the four incidents she was willing to discuss in depth. We traced this state of mind to an early past when she had an abortion when she was a teenager. She described that, at the time, she didn't believe her parents could 'handle' learning that she was pregnant so she decided to have an abortion. She, however, contracted blood poisoning and for two days as she described it, she had to 'put up with the pain'. She was finally hospitalised. When her parents discovered the cause of her condition, their expressed concern was only about what the neighbours would think about the abortion. Jane's silent response was, 'Who cares what the neighbours think!' But she reported in the session, 'I don't confront my parents that way'. She reported that she refused to say anything to them as she felt she had hurt them enough. She concluded that she would 'just have to put up with the fact that her parents didn't know how to deal with her'. She was so enraged at their reaction she couldn't express it. Within a week of her discharge from the hospital, she left college and went on a European tour with a new-found boyfriend. Jane believed she couldn't 'pick it up' after that, and couldn't return and clear it up'. She was hospitalised shortly afterwards for a manic episode. What she discovered regarding later

episodes, those that she was willing to talk about, was that there was a similarity in states of mind that she had experienced with her boyfriend prior to her recent hospitalisation, to other experiences with other boyfriends, with her former roommates and with her bosses at various jobs.

She became enraged, would leave her situation, experience a manic episode and then was arrested or re-hospitalised. Key was that she believed she couldn't talk to anyone about what she experienced because she believed it wouldn't do any good and she had 'to put up with her anger'. She realised that she had a similar state of mind with her parents at the time of the abortion. This same state of mind occurred many times and functioned to minimise reflections and her ability to anchor her insights even while we were exploring her problems.

For Jane, she would have to realise that to 'put up with it' was false and didn't fit the situations, but she would have to see many times in many situations how this idea has played havoc in her life and what were the conditions in early childhood that convinced her that she couldn't talk about such important matters and thus believe the false belief that she had to 'put up with it'. To only challenge the logical inconsistencies of these ideas would not reveal the origin and purpose for their acceptance and why they continue in the present. To test the significance of any insight the patient must return and attempt to pursue their goal to learn what changes have occurred.

PM/GDRP seeks to identify and understand the function of these beliefs, their origin, the nature of their transmission, their form or morphology, their relation to one's self-image, the content of the counterattack to their being revealed, and the reason for their continued maintenance in the present in terms of its function within the family dynamic.

Once patients learn that they accepted false beliefs not true about themselves, they can then learn why they accepted the false beliefs, what purpose they served within the family structure and why they have continued into the present.

Jane unfortunately stopped her treatment, because she believed she shouldn't confront the reasons why she accepted these beliefs any further. She may have had to learn why she accepted the family philosophy that she couldn't confront parents. At this point, Jane

obeyed her counterattack beliefs that guard the pathologos and block further explorations.

To the degree Jane was beginning to recognise patterns raised the possibility that her mental illness may not only be due to chemical imbalances but that these manic episodes may also be due to the loyalty to unquestioned false beliefs that led her to certain repeated behaviours and eventual re-hospitalisation.

From this client, it raises the question whether the root cause of Bipolar disorders may be due to cognitions or false beliefs, and that the internalised anger secondary to these false beliefs can distort perceptions and behaviours that lead to manic episodes. PM/GDRP introduces the possibility that causes for the severely mentally ill may be found in the individual's understanding and view of the world that are based on false beliefs. And most importantly, it also introduces a dialectical philosophical methodology that brings the individual to identify these false beliefs. Thus, PM/GDRP hypothesises that at the root of behavioural and possibly some physiological symptoms is a fundamental false belief.

Fred, our second case, was a self-proclaimed philosopher and prophet, who was from a family of considerable wealth. He was a well-educated individual who found little in the conventional world. Fred had numerous psychiatric hospitalisations over a 25-year period after he manifested auditory hallucination, self-endangering behaviours or threatened suicide. He reconstituted quickly and then would be released from the hospital. He had been treated mainly through medications and had little individual therapy. He also reported he had not found any challenges in his prior hospitalisations.

He had a delusion that there was going to be an apocalyptic occurrence on a specific date. He believed that only a few hundred thousand people would survive and he would be the ruler. He believed himself a prophet and that he was helping the world by giving them these prophecies. He thought he could read divine signs, and had little doubt that his prophecies would come true. In this state of mind, he didn't care what others thought of him and he didn't have to live up to any image. He was special to himself. He had his friends, his imaginary friends. He made his delusions into a religion and he was both their preacher and disciple.

When the specific date came and his prophecy failed, he was greatly disillusioned, and he experienced great distress. He tried many tactics to revive his delusion, but it failed. He was exhausted and drained after his prophecy didn't come true, as he believed he knew the truth.

Fortunately, we had been exploring for some time his states of mind prior to his auditory hallucinations. He enjoyed exploring his patterns of thinking which may have lessened the severity of the disillusionment. When he chose the goal of staying concentrated in his group sessions, he noticed he would 'take off' into his private world and miss the points of the discussion. He described them as 'glitches'. When he was brought to reflect on that moment, again and again, when he lost the point of the conversation and slipped into one of his 'glitches', he realised there was a pattern. He noticed it occurred especially when he didn't understand something or he was angry about what was being discussed. He was now recognising there was a pattern behind these 'glitches', that they had a source, and that they were disrupting his goals.

This was in total contrast to his private world, where he believed he was in total command and understood everything past, present and future. When his prophecy failed, however, he was confronted with the falseness, at least to some degree of his prophetic powers. He was in distress because his own world of fantasy failed him and he didn't understand why. At this point, in our sessions, he was more open to describe his personal experiences when he was in his 'prophetic' state of mind. He described himself as being absolutely sure, and a unique individual. He had delusions that he was the president, a rock star, a philosopher and, of course, a prophet. Because he believed he could predict the future he believed himself a superior human being. He felt he could do whatever he wanted, felt clear, lucid, and confident. In tracing the history of this state of mind, he revealed that when his mother appeared to him to be most together in mind, most rational and logical was when she appeared to him as being 'philosophical'. She would make parallels to the past, appear to have great understanding of the world and make what appeared to him to be prophetic statements. When she was in this state, expounding her beliefs, she would further say to Fred that, 'If you can't make

these parallels something was wrong. There are some absolute truths in history'. His father would not challenge his mother, and thus, he accepted a way of being from his mother as real and acceptable.

He was shocked to discover that what he would say to himself in his private world, or when he was predicting the apocalypse, he had heard many times from his mother, and as his mother, he would say them as absolute truths and expect the world to listen to him as he had to with his mother.

PM/GDRP allowed Fred to catch a glimpse that he had been functioning under false beliefs and that these false beliefs had an origin that could be traced to early learning scenes with his mother and father. This realisation made rational to some degree his present experiences. The father wrote a letter to the hospital stating that his son was the clearest he's been in 25 years. Some may argue that this change was not due to the application of PM/GDRP principles, but rather to other factors. That would certainly require a thorough study. Going by what the patient said, however, he was surprised to learn to some degree that the way he perceived his world had its origins from early childhood. It now made sense to him, in part, why he behaved the way he did. Fred, as you recall was described as someone who found little in the conventional world. Soon, after his insight about his mother, he had a dream where he had the choice of jumping from a high building on to a fast moving plane or taking the conventional way to catch the flight. This patient after twenty-five years made the choice to take the conventional route. At the time of this writing, he was attending school, living independently and had not been re-hospitalised.

The reasons for accepting these beliefs often are not explored with these individuals. For often when they reach a place where they function better than before they are released from the hospital. It would be of extreme value if once discharged similar types of discussions could be carried on as the person takes on new challenges. Unfortunately our system's belief in the gods of economics makes little room for such considerations.

What we find by applying the principles of PM/GDRP to the severely mentally ill population is that it helps raise their awareness of their own problems as problems. Even in modified versions of

PM, as GDRP, the individuals are drawn to focus on their ideas and thoughts, something few have reflected on or have been given a chance to do so. When they are able to follow the dialectic, to whatever degree, they become more self-reflective. They become more responsible for their actions when they are brought to see the possibility that their behaviour is understandable and due to false beliefs they have learned and accepted from childhood. And for those who are able to engage in this process, they become more motivated to pursue their goals. For to the degree they are able, they realise they have a way of understanding that false beliefs block them. With deeper reflection they may come to realise the causes for accepting the false beliefs that block them and why they have continued to manifest in repeated problematic behaviours in the present.

Thus, what PM/GDRP brings to this population is not the full use of its power, but raises the awareness of the individual to his/her own problems as their own, and that their mental illness has its origins in false beliefs. It is through this rational/cognitive method that some individuals who have had years of chronic mental illness and criminal behaviour have been able to discover to varying degrees that their behaviour has a reason for being, due to the false beliefs they have been loyal too and of which they learned in early childhood from those they found to be most significant.

PM/GDRP brings to the world of psychological treatment a model for understanding the reasons or causes for the suffering one experiences in one's life. It provides a model for understanding repeated problem behaviours, relapse and/or recidivism. It brings intelligibility to the individual and brings the practitioner to realise how profoundly the mind continually communicates with us for our benefit. Practitioners, using PM/GDRP principles, gain a deep, rich appreciation for problems and realise that any interpretation deprives both parties from insight and understanding. It raises the awareness of the functioning of mind and allows us to explore its depths.

In conclusion, we have found that this form of rational inquiry has its application in areas that have been believed to be unapproachable by rational means; and that it has an application for uncovering fundamental beliefs and their cause that underlie relapse, re-hospitalisation and recidivism. It is hoped that with further analysis, this method can

give us insight into the dynamics of serial behaviour. It also raises the question whether there are a definite number of pathologos types that can be classified much like in the Diagnostic Statistical Manual for Mental Disorders-IV-TR (2000).

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