Psychopathology of addictions

G. Di Petta

S. Maria delle Grazie Hospital, Female Prison, Addiction Centre Consultant, Mental Health Department, ASL Naples 2 North, Italy

Summary

This paper intends to examine, both from a psychopathological and a phenomenological perspective, the state of "being-at-the-world", which is common in individuals with drug addiction. Past abuse, as well as present abuse, are crucial in the modification of the psychiatric impact in the history of drug abuse. The former drug lifestyle characterised by the use of heroin led to a form of psychosis which is known with the symptomatological expression as basic psychosis. On the other hand, the contemporary poly-abuse of novel psychoactive substances leads to what is called a synthetic psychosis: a very rich paraphrenic state with continuous hallucinations caused by a mental automatism syndrome and secondary (interpretative) delusions. From a phenomenological point of view, all addictions lead to the final collapse of the Dasein structure (the constitution of the being-in-the-world-with-others). Subsequent to having travelled down many different psychopathological pathways, many addicts remain without the spatial-temporal "here and now" dimension. This makes it impossible for them to stay in a space-with-others and to project themselves in time. The result of this time/space cleavage is emptiness. It is very difficult to treat this existential situation, which is characterised by patients frequently dropping out of conventional treatment, the loss of the being-in-the-world structure, boredom, emptiness, dread, anger, lack of meaning, loneliness and isolation. In this paper, Dasein Group-Analysis (an original interpretation and application of Binswanger's Dasein-Analysis) is proposed and discussed. Unlike Dasein-Analysis, this approach applies phenomenology beyond the classic pair of analyst and patient, to a group of people composed of doctors and patients, in which everyone is simply a human being in the world. If the psychopathological and therapeutic approaches prove to be ineffective, the frequent consequences are: the patient's admission into a psychiatric hospital; his/her arrest for crimes related to antisocial behaviour; a worsening of their psychopathology and addiction; a diffusion of infective diseases commonly found in addicts; more frequent overdoses; aggressive behaviour; legal problems; an increase in the costs of public health system; and, finally, even suicide of the patient.

Key words

Polyabuser • Novel psychoactive substances • Paraphrenia • Endogenic psychosis • Exogenic psychosis • Phenomenological approach • Psychopathology of consciousness • Phenomenological group

Take me on a trip upon your magic swirlin' ship
/ My senses have been stripped
my hands can't feel to grip / My toes too numb to step
wait only for my boot heels to be wanderin.
Then take me disappearin' through the smoke rings
of my mind
down the foggy ruins of time
far past the frozen leaves…
Let me forget today until tomorrow.
Bob Dylan

The field of battle

Psychopathological syndromes are ever more frequently characterised by psychiatric symptoms and substance abuse in clinical practice. However, the connection between use, misuse, abuse and polyabuse of substances and psychiatric symptomatology is unclear. The same substances, in fact, can both reveal and cover an underlying or contemporary mental disorder. Recently, the change in abuse, for example polyabuse of mixed and often synthetic exciting substances, has reduced the traditional "covering effect" of opiates. In addicts substances strongly influence the clinical form of psychiatric disorder, connecting it to addiction. On the other hand, there are many psychiatric outpatients who take substances on the road and become addicts after that. In this case, even the primitive psychiatric syndrome in addicts changes its clinical form. It is very important to clearly identify the *cluster* of symptoms that indicates the presence of psychiatric alteration in addicts, in order to treat patients with opiate agonists, along with psycho-pharmacotherapy, psychotherapy and rehabilitation. However, in order to do this it is crucial to try to understand – through Jaspers [1], Schneider [2], Bonhoeffer and de Clerambault's [3]

Correspondence
G. Di Petta, Psychiatrist and Neurologist, S. Maria delle Grazie Hospital, Female Prison, Addiction Centre Consultant, Mental Health Department, ASL Naples 2 North, Italy • E-mail: gilbertodipetta@alice.it

psychopathology – how the developing psychosis bases itself on the addiction background. The crucial question of this discussion is about the switch/crossing point between the toxicomanic experience and the psychotic experience, identified in a particular state of consciousness, the *twilight state*. In poly-abusers of novel psychoactive substances (NPS)[a], however, it is important to identify and to define a specific mental automatism as a primary elementary phenomenon, and to consider the consequent thought disorder a secondary phenomenon.

The "addicted" consciousness

For psychiatry, the psychopathology of consciousness has always represented a sort of final frontier. From Janet's studies on the splitting of consciousness to Ey's studies on the de-structuring of the field of consciousness, there is no psychiatric disorder that cannot be collocated on the ground of consciousness. According to Jaspers, the ego-consciousness can be understood in four ways: 1) sense of activity; 2) sense of uniqueness; 3) sense of identity; 4) sense of oneself [1]. It is very clear how subjective consciousness here limits the field of experience of one's *being-in-the-world-with-others*, the dramatic change of which indicates the beginning of psychosis. The assessment of a state of consciousness is fundamental when the psychopathologist is face to face with addicts under the effect of substances. In this type of encounter, the clinician perceives the boundaries between the areas of consciousness where there is attunement and the areas of consciousness where there is no attunement. For example, if we assume that depersonalisation, de-realisation and dissociation are global experiences of the formal destructuring of the field of consciousness and not simple symptoms, we can also find them in a broad spectrum of psychiatric disorders, from schizophrenia to panic attacks, from phobia to dissociation, from post-traumatic-stress disorder to somatic disorder, from addiction to withdrawal. At this point, we come to the following conclusions:

1. consciousness is a field with formal and fundamental characteristics and there is no psychiatric disorder that does not have its background in modification and de-structuring of consciousness;
2. the causes of disease that produce modification of the ordinary state of consciousness, especially substances, strongly influence the development of psychiatric disorder, touching many aspects of psychopathological vulnerability.

The crossing-point of the "twilight state"

What do the addicts mean when they say: "I am high?" What is the psychopathological meaning of this state of consciousness (*highness*) which for them represents a sort of steady-state of daily living existence? Probably the experience of *highness* is an equivalent of a *twilight state* of consciousness (*Zwielicht-Daemmerungzustand*). This modification of the state of consciousness is well represented by many current expressions: numbness, clouding, drowsiness. In the classic description of Jaspers [1] and Schneider [2], a *twilight state* of consciousness is a restriction of the field of consciousness. In the *twilight state* of consciousness, there is no dramatic alteration of arousal. The field of consciousness, furthermore, can still spread itself (Fig. 1). The *twilight state* of consciousness is a sort of threshold between the light of reality and the shadow of dream and psychosis. The *twilight state* of consciousness promotes illusions, delusions, visual or auditory hallucinations: the patient may respond to them with irrational behaviour. The person may be unaware of the surroundings at the time of the experience and have no memory of it later, except perhaps to recall a related dream. De-personalisation and de-realisation are normal experiences in the *twilight state* of consciousness, in which it is easier that Klosterkötter's transitional phenomena take place, from basic symptoms toward final phenomena [4]. Heroin addicts experience this vulnerable condition every day, every month, every year, over a prolonged period of time. The perception of reality in addicts is discontinuous and incomplete, and this *twilight state* becomes a sort of normal way of life. Their state of consciousness is like a display that is continuously turned on and off, short flashes appear and disappear. Being instable, the *twilight state* becomes a transitional state, like a *funnel*. When the *funnel* is upside down, addicts lose touch with reality and fall into delusions.

The "basic" psychosis in heroin addicts

When psychosis begins to manifest itself in heroin addicts it is very difficult to differentiate typical schizophrenia from bipolar psychosis. This "twilight psychosis" remains a sort of cluster of basic symptoms, in which mood, cognition, thought and perceptions are all affected. In this *twilight state*, a particular form of psychosis eventually develops: "basic psychosis". In this "basic psychosis", cognitive and thinking symptoms are confused with perceptive and mood symptoms. The recognition and the

[a] An increasing number of unregulated websites are dedicated to the dissemination of novel psychoactive substances (NPS), which include plant-based compounds, synthetic derivatives of well-established drugs, as well as "designer medicines".

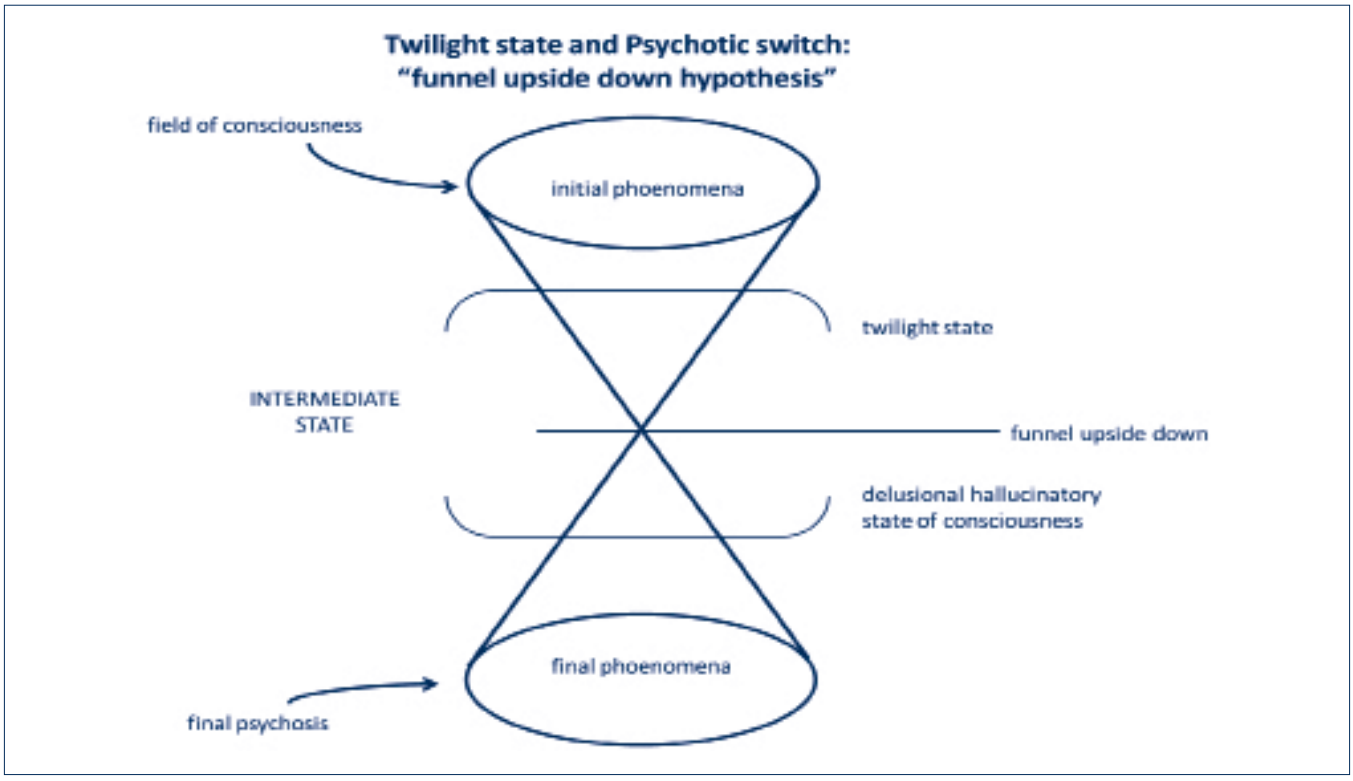

FIGURE 1.
This figure shows how the initial field of consciousness reduces itself until the crossing point, after which the field of consciousness is inside-out and instead of looking out is polarised on psychotic phenomena.

assessment of this "basic psychosis" can be done by basic symptoms interview (FBF, BSABS) [5 b].
"Basic psychosis" is characterised by one or more "basic stages". It is very difficult to classify this "basic psychosis" in heroin addicts. Psychiatrists do not often recognise it and as a consequence fail to treat it. This "basic disorder" causes severe discomfort in addicts and induces them to self-administration of substances. Mental functioning is disturbed by this basic symptomatology. Many addicts don't give up substances because they feel acute discomfort of "basic psychosis" when they are drug free. Substances cover and aggravate the "basic psychosis". Very often, basic irritation doesn't proceed towards externalisation and concretisation of the final psychosis. This is a germinal psychosis, a mixture not differentiated by affective and cognitive elements, which often remains at the initial stage, and then freezes with no further progression. Without progression and without differentiation, there is neither personality deterioration nor stabilisation or residual psychosis (the patient remains constantly unstable). When these traditional addicts suffer from psychotic symptoms, i.e. *revelatory* delusion, they have the experience of the pleasure of aberrant meaning, and show a different sensitivity to substance abuse. The "meaningful delusion" represents a milestone ("before and after") in the life of these patients. This "before and after" is in competition with substance abuse and determines a new *imprinting* connected to successive substance relapse. In some of these patients, delusional relapse completely substitutes relapse of substance abuse. In these cases, delusion seems to become a sort of "endogenic drug", having the same effect as an exogenic drug on the life of patients. The experience of "salience", the underlying dopamine and relapse are crossover concepts between drug addiction and psychosis. The aim of good treatment with opioid agonists is global mental stabilisation and not just oriented to the morphinuria negativisation. Decreasing the dosage of opioid agonists is dangerous, especially when mental disorder is concurring. The risk of transforming a heroin addict into a mentally ill patient with-

[b] Basic symptoms are described by Huber, Gross (1986-1996) and Klosterkötter (1992) as alterations of subjective experience that indicate the beginning of psychosis. The sequences of transition by Klosterkötter lead the transformation from basic symptoms to final phenomena. Several basic symptoms together constitute a psychopathological condition defined as "basic stage".

out opioid treatment is high. Often the heroin addict is a "masked" psychotic, or a "basic" psychotic. On the other hand, heroin addiction undermines the patient's sense of reality and the patient's coherence of self. The area of drug vulnerability is the self concerning experience[c].

The "chemical madness" induced by NPS: the "Alice in Wonderland" syndrome

Seeing something out of the ordinary visual field, seeing an unreal (inexistent) landscape, a bizarre environment, geometric forms; seeing bi-dimensional and flat images added to the ordinary visual field: all these are common visual perceptions induced by hallucinogenic drugs. It is not easy even for a general psychiatrist, even one well versed in all things medical and psychopathological, to deal with these emerging (chemical) hallucinatory-delusional patterns. The diffusion of NPS in young people is responsible for a new pattern of mental disorders induced by substances: chemical psychosis, which can also be called "synthetic psychosis", is a sort of "Alice in Wonderland syndrome"[d]. This is the paradigmatic speech of Stefano – "I have to say that I have been hearing voices ever since I was a young child though I only started to have visions after the breakdown I had when I was 20. I remember the first time I heard voices. I was two or three years old and I was sitting in my high-chair and I could hear them talking to each other but I couldn't understand what they were saying. Then the voices noticed that someone was listening to them. Now I can say that those voices already knew the meaning of everything that has happened to me since then. When I was four years old I was in the front yard of my house and I heard the female voice that I already knew and then three aliens came out of a hole in the ground and I walked towards them and I was ready to throw myself into their arms not knowing that they were the incarnation of evil. As I have already said I was four when the aliens took me with them on a journey into another reality controlled by a different logic from ours. I was there for an indefinite time which might have been all of eternity, though compared to time on Earth it was just a moment". In spite of the evidently severe hallucinatory dimension causing delusional interpretations, there is no evidence that shows NPS is able to induce thought directly. However, NPS severely compromises reality testing. How are criticism and judgment really effective in the reality testing? NPS probably compromises human *sensorial* knowledge. Firstly, classic consciousness philosophy, based on Descartes' and Kant's conception, is no longer a good model for NPS induced synthetic psychosis [6-9 e]. "The man thinks, not the brain" was the conclusion of E. Straus, the author of "The Sense of the Senses" (1930), in which sensorial consciousness is common to animals and human beings [10]. From the perspective of these authors the world of life is embodied, there is a logic of living, we can find an *a priori* structure of feeling, there is a spatial-temporal horizon of feeling, the sensorial experience is active and cognitive, the *pathic* dimension of existence has a communicative structure. In Straus's theory (1930), *seeing* is the immediate consciousness of spatial distance. It is a sort of temporal scanner, and *touching* is the nearness receptor. Aesthesiology ("Theory of Feeling") by Straus allows us to understand that the approach to reality is based on and guaranteed not by criticism and judgment but by pre-verbal, pre-reflexive arguments; that the perception-movement cycle is crucial in the structure of common sense. As a consequence, drastic modifications of the perception-movement cycle, caused by NPS, can influence (though only in a secondary way) both criticism and judgment [7]. Therefore, chemical delusions are not primary, but secondary to strong modifications of the relationship with reality, based on perception-movement distortion induced by NPS.

"Synthetic" psychosis *versus* "classic" schizophrenia: a differential diagnosis

Various typical psychopathological signs of schizophrenic syndromes (e.g. the crisis of "Me-ness" and the invasion of "overconcern me relationships" (Schneider, 1950), the crisis of "basic trust" (Husserl, 1907) [11], perplexity (Callieri, 1997) [12], the "exclusion of casuality" (Berner, 1981) [13] and the "loss of overall perspective" (Conrad, 1958) [14] are unknown in these synthetic syndromes. Where, then, are the classic psychopathological

[c] Sense of self, self-experience, proto-self, self-agency, self-coherence, selfhood, self-consciousness, ownership – are all domains severely compromised by lifetime drug abuse.

[d] The "Alice in Wonderland syndrome" was described by Todd (1955), Lippman (1952) in migraine and epilepsy, and is characterised by morphological fluctuation, such as Metamorphopsia, Micropsia, Macropsia, Temporal distorsion, Temporo-occipital lesion, Parieto-occipital lesion.

[e] The idea of the Gestalt's cycle (Gestaltkreis) by Victor Von Weizsaecker (1886-1957), instead, is a better model to understand NPS psychosis. The cycle "perception-movement" is probably the first and the principal target of NPS. H. Plessner (1892-1985) and M. Merlaeau-Ponty (1908-1961) gave a strong contribution to identify and define this perception/sensation area. J. Zutt (1893-1980) also wrote about this aesthetic field of lived experience (Das aesthaetisches Erlebnisbereich).

signs, such as delusional atmosphere or delusional perception, in these post-modern *chemical* patients? How is counter-transference or attunement possible in these postmodern psychonauts? Is it still important to understand life history *versus* the hallucinogenic power of the "plants of God"?[f] In chemical delusions, for example, we do not have: 1) a delusional atmosphere; 2) delusional perception; 3) primary delusions. The NPS are not really able to induce thought disorders. Chemical delusion is characterised by *confirmation* and *interpretation*, not by *revelation*, and by fantastic contents. NPS delusions are like paraphrenic delusions[g], with a feeling of unreality while at the same time maintaining the ability to analyse this feeling [15]. On these differential signs, it is possible to set a precise distinction between chemical delusions secondary to NPS *sensory* modification and primary delusions of classic endogenic psychosis. The core gestalt of these contemporary psychonauts' psychosis is far from that of classic naïve psychotic patients. For acute syndromes, the exogenic psychosis[h] is still a good model. Many acute clinical conditions in these "chemical patients" are brain organic syndromes (*Durchsgang-syndromen*). After acute symptomatology, differential diagnosis is often possible between naïve patients and chemical patients. De Clerambault's concept of delusion[i], based on the mental automatism syndrome[j], is a very good model to understand this synthetic psychosis. In this atypical psychosis, a part of the patient's ego remains a critical spectator of his or her own pathology (a spectator of the internal/ extraneous psychoma) [16]. The ego goes mad in its desperate attempt to "synthesise" (repair) the profound wound opened by dissociative drugs (Table I).

TABLE I.
Classic schizophrenia symptoms compared with synthetic psychosis symptoms.

ENDOGENIC psychosis (classical psychosis)	Exogenic psychosis (synthetic psychosis)
Lucid consciousness	Twilight consciousness
Thought	Sensory perception
Self-concerning ontological insecurity	Object-concerning instability
Delusion: primary, metaphysical, systematic transcendental ego	Delusion: secondary, everyday, phantastic empiric ego
Fusionality, passivity	Insight, agency
Bizarre and inexplicable behaviour	Impulse discontrol and aggressivity
Autism	Anaclitism
Progression	Basic and germinative
Distance/apathy	Overexcited/excessive emotivity

[f] These are often sold as something else, e.g. mystical incenses, plant chemicals and bath salts, herbal smoking blend (synthetic cannabinoids, Spice drugs, mephedrone).

[g] Illusions and acoustic, olfactory, gustative and cynesthetic hallucinations, but especially chronic delusion in which imagination and fantasy, leading to bizarre and unrealistic situation, are fundamental. Another common case is the feeling of being persecuted by strange electronic machines. Other cases include patients who believed they were: without vital organs, responsible for "the end of the world", the son of famous historical figures, protagonists of epic events and in communication with aliens. In differential diagnosis with schizophrenia, the personality cohesion and the affective participation in these cases are not completely damaged, and social skills and personal autonomy are well maintained. The patient lives two lives at the same time (one real and another imaginary and delusional), which, however, does not completely compromise his behaviour and his relation with reality.

[h] Toxic psychosis, traumatic psychosis, brain disease psychosis, delirium, progressive paralysis, withdrawal psychosis: these are the exogenic psychosis described by Bonhoeffer in 1914.

[i] G. de Clerambault was the Director of the Special Infirmary for the Insane (prefecture de police, Paris 1905). He described many patients intoxicated by absinthe, clorhalius hidratus, ether, hashish and alcohol.

[j] The mental automatism syndrome is characterised by: ideoverbal basal syndrome, various different types of voices, usually threatening, different kinds of hallucinations and pseudo-hallucinations, inside spoken thoughts, stolen thoughts, and visual, taste, olfactory, cynesthetic and sensorial hallucinations. Parasitism of abnormal perceptions: tingling, irritation, itchiness; in de Clerambault's conceptions delusion is secondary to hallucinations. Delusion is not primary, the hallucinations are primary and the delusion is only the secondary interpretation of delusion. Motorial: cynesthetic impressions, sudden shudders, forced movement.

The phenomenological perspective: comparing the "floating" world and the "frozen" world

Obviously, being a human being is something completely different from being a crystal, a drop of water, or a plant. The relationship that exists between man and reality is a clearly understandable system of intentional acts. This *being-at-the-world*, seen from a phenomenological perspective, is the ontological structure of every human being, and is based on the connection between the subjective (living) consciousness and the objective (lived) world. Intentionality (aboutness, directedness) embodies the immediate contact with the world.

Drug addiction undermines intentional consciousness. Whereas in normal conditions we have a fluid intentionality and our common sense is the obviously pre-reflexive result of this situation, under the influence of a drug intoxication we lose this intentional stability and, as a consequence, suffer from a kind of intentional instability, which we can identify with the term *floating world*. This floating world is characterized by splitting, vibration and a multiplication of images which can be both sequential or overlapping. On the other hand, following chronic drug assumption, we have a sort of an intentional dramatic capture or seizure of the world, which we can call *frozen* world. The lived time, space, body and other existential parameters differ enormously in these two contrasting ways of being.

For example, there exists a violent twilight state of consciousness in patients who are suffering from the effects of drugs and are, consequently, in the situation of a floating world. Their lived body has become disjointed. Their senses have started to become something like a wild kaleidoscopic. The lived space is haemorrhagic and the perception is of a loss of space, of being nowhere.

The patient's existence is centred around where the pusher is – the exact square, the road, the underpass. There is a contrast between the cold space of substance suffering which can be defined with the word "absence", and the hot space of substance enjoying which can be defined with the word "presence", and with the vanishing space under substance effect (which turns the addict into a maniac).

Lived time is liquid and indefinite. There is no present, no past, no future. Having lost the connection of interior time all the drug addict has left is the transient moment of satisfaction. However, as soon as the drug addict achieves a moment of pleasure it suddenly vanishes and he is condemned to impulsive and compulsive repetition. When the patient experiences craving, both past and future have been lost. The past is reduced exclusively to "the last time in which I have taken drugs". When the patient experiences highness, he feels so absorbed in the present that he is no longer able to see the future. Not experiencing the past and having lost touch with the future the patient ends up being unable to grasp the present. "The addict is trapped in this repetition with no chance of moving forward" [17]. The instantaneity[k], the pure instant is the "hole" between the last dose and the next one: the liquid instant of "high" rules. The moment of altered consciousness and the time of the depthless instant dominate everything else. Thus, the patient is trapped in a sort of circular liquidity of lived time, and suffers the pure illusion of linear movement. Everything is manipulated and everyone is reduced to just being an obstacle in the way of the addicts only remaining relationship – with the drugs he takes.

On the other hand, following chronic intoxication, the patients' consciousness becomes viscous, and the lived body is blocked – now he finds himself in the state we call the frozen world. The body is modified on a neurobiological level by a chemical graft which inserts a relevant new artificial element into the lived body. The object body (*Koerper*) is the vehicle of powerful substances which can successfully alter all sensations and perceptions, and the whole world experience, reducing the addict's self into nothing more than a denatured, mineralized body (*Koerper-ding*). His intentionality is coagulated, time is insular and has been reduced to a pure frozen present without past and without future until the complete loss of the passing of time[l] is experienced) – others have become unattainable objects which are lifeless, like unattainable distant snow-men. Tragically these patients become mere bystanders to their own existence. In order to feel themselves still alive they need more substances. The crisis of the temporal-spatial vortex eventually and inevitably

[k] "Under the influence of hashish the mind can fall into the strangest illusions of time and space. The time seems to pass incredibly slowly. Minutes become hours, hours become days; soon any precise idea of duration is lost, past and present are mixed up. The speed with which our thoughts follow each other, the resulting ecstatic condition, explain this phenomenon, because if time seems to be longer than it would have been if measured with clocks, it is the actions and events that occur in this period of time , that extend the time limits with their magnitude" (Moreau de Tours, *Du Haschish et de l'aliénation mentale*. 1845).

[l] "Time is dead; years, months, hours will no longer exist; time is dead and we'll go to its funeral. […] The clock hand will stay on the minute in which time ceased to be, and your torment will be to go back and look at the motionless hand, and to sit down again in order to start all over again, and this will go on until you find yourself walking on the bones of your feet […] The suns will explode and become dust before the metal hand has moved one millionth part of a millimetre" (T. Gautier, *Le club des hashishin*, 1845).

TABLE II.
Progressive development of the addict life-world, identified by the modification of the fundamental existential parameters.

"Erlebnisse" characteristics			
Psychopathology	Vulnerable personality	Psychopathy	Synthetic psychosis
Intentional consciousness	All is easy →	"High" friendliness to soft soap →	Intentionality collapse
Spatiality	Emptiness →	Mask or facade →	Dasein collapse or rupture
Temporality	Fluttering	Instantaneity	Time stands still (zeitstillstand)

leads to the blow of the void (*le coup de vide*): the experience of unreality or no self experience. The total collapse of the world is the common final destination/ result of the breaking down of the temporal and spatial structure of "being-there"("Da-sein"). *Being-in-nothingness* becomes the typical state of addicts in the frozen condition (Table II). In this case, the frozen condition has become a sort of terminal point in the existence of addicts.

A phenomenological approach to the treatment of addicts: the Dasein Group Analysis

This phenomenological approach to the psychotherapy of addicts has been applied since 1999[m] in addiction centres with everyday contact with patients, and always creates an intense emotional atmosphere[n]. In many of these patients, the human sense of identity is lost even where there is no psychotic symptomatology. In these cases, the only way to survive is to achieve vital contact with another person, feeling empathy for the emotional, affective dimension of another person. The "epochè" is the preliminary condition of this setting, especially when this requires the doctor to abandon his own role. The lived experiences mix freely in a totally emotional context [18 19]. Subsequently within the group the shared emotions reveal a truly meaningful lived dimension, made up of pain and pleasure, helplessness and happiness, loneliness and nearness, anger and friendship: a sort of "fundamental affective position" (Heidegger's *Befindlichkeit*). This group approach is centred on the search for an authentic inter-subjective encounter, as the crucial embodied event. This condition, which happens *face-to-face* between two human beings in the middle of the group, is the necessary step for any subsequent cure[o]. The phenomenological background has been extremely useful especially in the close encounter (*face-to-face*) with the patient who is seen more as a real person than as just another clinical case. The lived experience, here, (any lived experience including delusional or hallucinatory experiences), has its own intentionality (aboutness). These experiences in the emotional context of the phenomenological group freely mix with each other, producing change and transformation in all participants. The passage from initial negative emotions to final positive emotions in each group session is crucial. It is like a journey from helplessness to hope, from pain to light, from loneliness to intimate nearness. The therapist here is not outside the group, but completely inside it[p]. Both the therapist and the patient abandon their roles and are in the phenomenological group as human beings *body-to-body*, *existence-to-existence*, as persons who love, cry, feel without the barrier that exists between *therapists* and their *patients*. From being *one-next-to-another* (*Nebeneinandersein*) and from being *one-in-front-of-another* (*Voreinandersein*) to *being-one-with-another* (*Miteinandersein*).

[m] One of the most important ideas of phenomenology, in fact, is the deep union between the subject, other people and the world-of-life. This idea offers an enormous transforming potentiality, which is very useful in a modified setting of group psychotherapy.

[n] This idea of a plural phenomenology (*being-we-in-the-cure*), the realisation of Binswanger's *weness-which-loves*, in an emotional group composed of doctors and patients together, was a result of hopelessness due to failed encounters with the addicts' existences. The intention was to offer a common and intimate place, a new space, a new time, in which anyone was able to have the chance to feel his or her own existential condition completely. The chance to feel one's own body again and that of another, the possibility to feel one's own pain again and that of others, to feel the support of others, the possibility to cry one's heart out. Among some of these lost existences, this new phenomenological approach has become a sort of way out, which through cure can eventually lead to freedom and the world.

[o] This phenomenological approach to group therapy is quite different from the psychoanalytical approach to group therapy. In fact, it is based on consciousness and not on the unknown. The phenomenologist sees the essence of phenomena, he does not use interpretation, whereas the psychoanalyst is more interested in recording the hidden meanings beyond the phenomena.

[p] An evident difference when compared to psychoanalysis is the complete involvement of the therapist as a human being in the emotional dimension of the group, in the same way and at same level as the patient.

This gives them the chance to live in a space and time in which it is not important to answer the question "who am I?", but the question "what do I feel"? and "how do I feel"?[q]. Starting from a common emotional land, in which we can find our lost parts, in which we can give to others the parts they have lost which we can find in our own internal experience, and in which there is the chance to look for and discover these parts which are still alive[r]. Group participation is open to everybody, no matter what his or her condition is. Anyone from anywhere is admitted to this new kind of group. At the end of the group session, it is evident that not even heroin is able to calm anyone more than a warm hug between two human beings; and that life itself is a greater excitement than cocaine. From a phenomenological point of view, the form (i.e. essence or *eidos*) of the lived experience (*pathos*) is crucial. The form of lived clarifies itself. Sometimes the people who meet each other in the centre of group change. The atmosphere changes and gradually becomes more positive. The internal pain and anguish became hope and light. The lived experience (*Erlebnis*) recalls another lived experience, becomes another lived experience, looks for another lived experience. If it is authentic, it is also therapeutic. At the end of the group session all the participants feel harmony. The therapist concludes speaking about his lived experience. Two hours have passed. Someone is still crying silently. The mixture of pain, anger and helplessness has led to a feeling of relief. We may wonder how it has been possible to achieve positive emotions, starting from negative ones. Is it not, perhaps, the World-of-life (*Lebenswelt*)? [20-22].

Conclusion and perspectives

Basic psychosis and synthetic psychosis in addicts are characterised by an underlying symptomatology, because substances effectively cover and block the appearance of easily diagnosed mental disorders. Basic psychosis is made up of several clusters of basic symptoms, (i.e. basic stages), synthetic psychosis, on the other hand, is characterised by a paraphrenic syndrome reactive to a mental automatismus induced by NPS. These clinical forms of *non-classic psychosis* are pervasive and common disorders in addicts which limit social functioning of patient and encourage continued addictive behaviour. It is important to identify these forms of psychosis in addicts in order to treat them adequately. The destiny of an addict can depend entirely on the recognition and treatment of these disorders. Basic symptoms inventory (FBF) is very useful to identify the presence of a basic state and can lead to treatment. The aim of the recognition and early treatment of basic symptoms in addicts is: 1) to block the transition from basic psychosis to final psychosis; 2) to reverse basic symptoms when it is possible in ordinary experiences; 3) to help the patient in coming-out from substance abuse. In the NPS poly-abuser it has been possible to describe a new form of psychosis, not comparable with classic psychosis, such as that in schizophrenia or bipolar disorders. We can give this psychosis the name of "synthetic psychosis", or the "Alice in Wonderland syndrome". In this case, patients *are not* psychotic, they *have* a psychotic syndrome. This form of psychosis is nearest to organic psychosis or to psycho-organic syndromes. Both these psychotic syndromes are often non-responders to traditional antipsychotic treatment. However, these patients are not impossible to treat. Dasein group treatment is characterized by intense emotional warming [23 24 s]. In phenomenological Dasein group analysis, the experience shared by therapists and patients, session after session, is characterised by focusing consciousness on one's own internal experience, searching for the lost structure of one's own *being-at-the-world*, the encounter between one's own self and another, the rebirth of one's own ex-

[q] As the group therapist in an existential group session, I feel myself to be in search of a starting point from somewhere within my own personal experience in order to begin group therapy. In the penumbra of a deep silence I am waiting, for an intuition in my mind. Within the experience of my consciousness of the world of life (Lebenswelt), I find the concrete inter-subjectivity of the participants. This has specific colour, form, smell and sound. The initial silence within the group is complete. This pregnant silence is the necessary prelude to group therapy. What can I say about this special silence? What is this deep silence? I can feel the emergence of the anxiety of waiting in this silence. I can see the profiles of the faces, I can see the eyes, the bodies of everyone. I speak with simple words about my own lived experience, what I have in my heart and I use words from the heart. I am the doctor, the group leader, but at the same time I am the first patient of the group. I talk about what I am feeling simply, authentically as an ordinary human being at that moment: my anger, my pain, my tiredness, my shame, my guilt.

[r] Beyond the language of medicine and psychology, the essence of psychotic experience, for example, remains something that cannot be explained, even if it is possible to perceive it. Phenomenological language in this case must adapt itself to the heart of the lived experience.

[s] Empathizing means "feeling the other from within" (Stein, 1891). The "pathicity" of existence is the background of this phenomenological approach: Binswanger (1942,1957, 1958, 1963), Minkowski, (1971, 1973, 1980), Von Weizsaecker (1886-1957), Straus (1891-1975). Every feeling is a *feeling-of-something*: hate, disgust, love, desire, joy, sadness: H. Plessner (1892-1985), Scheler (1875-1928). Our feelings are not senseless state of consciousness or psychic facts, but concrete modes of existence in situations with others: F.J.J. Bujtendijk (1887-1974).

istential movements. Finding oneself and losing oneself, and finding one's self again, in an endless game of swapping of changing the intimate parts of oneself. The particular group atmosphere is composed of the following elements: lack of pre-selection, free accessibility into the group unrestricted by rigid rules, less structured actions, the presence of addicts, psychotics and normal people side by side, the assumption of the space and time of addicts (here and now) as group time. The desired objective is nothing less than freedom from addiction and stabilisation of psychotic syndromes.

Conflict of interest

None.

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