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Zelda Alpern
Dismantling the Dominant Discourse
of the Irreversibility of
Schizophrenia: Three Meaning-
Making Approaches to Psychosis

ABSTRACT

The dominant discourse of schizophrenia as an incurable and biologically determined disease was interrogated through the lenses of race, culture, postmodern philosophy as well as quantitative and qualitative data suggesting a causal relationship between trauma and psychosis (Ensink, 1992; Read, J., van Os, J., Morrison, A.P. & Ross, C. A., 2005; Romme & Escher, 1989, 1996, 2000). The superior outcomes of those treatment models that privileged psychosocial support over pharmaceutical interventions also called into question the primacy of the medical model, as did the longitudinal studies of the World Health Organization (WHO) and over-representation in diagnosis among African Americans (Osiezagha, in press). According to the WHO, individuals diagnosed with schizophrenia in non-industrialized countries had better outcomes than those in industrialized countries (Whitaker, 2010). Practitioners of Open Dialogue found that with increased social support 70% of those being treated for psychosis were able to recover without the use of neuroleptics, and that there was a negative correlation between use of neuroleptics and remission of symptoms (Seikkula & Arnkil, 2006). Forces that perpetuate the primacy of the medical model were explored including: individual and cultural countertransference; the financial interests of the pharmaceutical industry; and Western culture's privileging of rationalism, individualism and scientific thinking. The following meaning-making approaches to psychosis, all of which emphasize subjective experience, were examined: the Hearing Voices Movement; individual psychotherapy as informed by the interpersonalists (Sullivan, Fromm-Reichmann, Karon), intersubjectivists (Lysaker, Daroyanni, Orange, Atwood, Stolorow) and the phenomenological psychiatrists (Stanghellini); and the approach of Open Dialogue (Seikkula) developed in province of Western Lapland, Finland. Points of overlap and points of disjunction in the way these three approaches conceptualize psychosis, healing and treatment was explored with focus on power dynamics, interpersonal healing, medication, hospitalization, and the course and frequency of treatment. Case material was utilized to highlight the concepts discussed in this research that concluded with implications for current practice in the contemporary context of the United States.

**DISMANTLING THE DOMINANT NARRATIVE OF THE IRREVERSIBILITY OF
SCHIZOPHRENIA:
THREE MEANING-MAKING APPROACHES TO PSYCHOSIS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2013

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CHAPTER I

Introduction

In the United States, schizophrenia is most widely understood as a biogenetically determined illness. Those given this diagnosis are seen as unlikely to recover. A pamphlet for the layman produced by the National Institute for Mental Health (NIMH) states, “Schizophrenia is a chronic, severe, and disabling brain disorder that has affected people throughout history. About 1 percent of Americans have this illness” (2009). In the West, pharmacological treatment is the primary intervention offered by mainstream mental health practitioners. In the NIMH’s pamphlet, four pages were devoted to an explication of neuroleptic-based treatment, in contrast to one small paragraph suggesting Cognitive Behavior Therapy (CBT) as a possible intervention (NIMH, 2009).

However, in the United States and abroad, there is growing controversy about both the causes of and efficacy of treatment for individuals who have been diagnosed with schizophrenia. In a longitudinal study launched in 1969 by the staff of the World Health Organization it was reported that in the United States, Denmark and Taiwan, 40% of individuals diagnosed with schizophrenia were found to be “severely impaired;” whereas in the developing world (Nigeria, India and Colombia) 24% of those diagnosed with schizophrenia were judged to be “severely impaired” (Hornstein, 2011; Watters, 2010; WHO, 1979). A follow-up 10-country study initiated by WHO in 1978 reported that of patients in developing countries “slightly more than one third

had become chronically ill” whereas 59% of patients in industrialized countries had become chronically ill (Whitaker, 2010, p. 110).

The disparity in outcomes has been attributed to three characteristics of industrialized culture: 1) reliance on psychopharmacology; 2) the “othering” of individuals experiencing mental distress by labeling them with a psychiatric diagnosis; and 3) the social isolation that ensues from this “othering” (McGruder, 2004). Conceptualizing of psychosis as a chemical imbalance discourages a meaning-making approach to understanding patients’ internal experience and locates the problem within the individual. In the Lapland region of Finland, practitioners of Open Dialogue (OD) conceptualize of psychosis as a blockage of communication in the social network (Seikkula, 2002; 2012). Restoring communication through meaning-making is the primary intervention utilized by OD practitioners, and they have met with incontrovertible success. Treatment outcomes based on the utilization of the Open Dialogue method in Finland suggest a remission rate that contradicts NIMH’s chronic characterization of psychotic symptoms (Seikkula, 2003; Seikkula, 2012). Since the establishment of the Open Dialogue approach over twenty years ago

the appearance of new chronic schizophrenia patients at the psychiatric hospital has ceased... In an ongoing study of first episode psychotic patients, the need for hospitalization decreased, and it proved possible in many cases to replace neuroleptic medication with anxiolytics at the outset. Consequently, only 27% received neuroleptic medication during the two-year follow-up period ... This did not lead to poorer outcomes, given that 83% of the patients had returned to their jobs or studies or were job-seeking two years later, and 77% did not have residual psychotic symptoms (Seikkula, 2012, pp. 229).

A similar positive trend in outcomes for psycho-dynamically-based treatment prior to the adoption of the use of neuroleptics has been documented in the United States (Silver, 2002; Whitaker, 2010).

For many who practice in community mental health settings in the United States, the most we have to offer patients with psychosis or who have been diagnosed with schizophrenia is a referral to a psychiatrist who will prescribe neuroleptics, and referral to case management often leading to an application for SSI and gradual disenfranchisement and marginalization of the symptom-bearer. The social work code of ethics has enjoined social workers to “challenge social injustice” and “respect the inherent dignity and worth of the person” (National Association of Social Workers, 2008, pp. 5-6). Our ethical code instructs us to meet the client where they are, and to support their individual agency unless to do so would “pose a serious, foreseeable, and imminent risk to themselves or others” (NASW, pp. 7). This impels us to attempt as best we can to see the world from the perspective of our clients, rather than to perfunctorily dismiss their perspective as disordered thinking. Clinical social worker Kam-shing Yip writes,

Sullivan regarded psychotic experiences as a failure of the tripartite system, a loss of control of self-awareness, and autistic self-indulgence. All these are clients’ final adjustments to external threats and hostilities. Thus, social workers interventions should not be confined to the enforcement of clients’ medical compliance and life skill training. Social workers should try their best to help the clients to face or even alleviate their environmental stress and external threats (2002, p. 260).

Psychiatric diagnoses have long been mobilized in the service of social control. Drapetomania and Dysaesthesia Aethiopica were alleged mental illnesses described by United States physician Samuel Cartwright in 1951. Cartwright identified the former as what caused

slaves to run away; and coined the latter to describe the cause of “laziness” among slaves and free Blacks, the “cure” for which was whipping and compulsory labor (Jackson, 2002; Metzl, 2009). “Sluggish schizophrenia,” a term utilized by psychiatrists in the Soviet Union to involuntarily hospitalize dissidents and perform forced treatment of anti-psychotics and ECT, was characterized by espousing “ideas about a 'struggle for truth and justice' are formed by personalities with a paranoid structure,” according to Soviet psychiatrists (Applebaum, 2003). While these examples are time and culture-bound, they are not a thing of the past. In 2005, an analysis of 134,523 case files revealed that African American men continued to be four times more likely to be diagnosed with schizophrenia than whites even as the NIMH and medical textbooks claimed that schizophrenia was a biological disorder that should occur in 1% of any ethnic population (Metzl, 2009). It also has been pointed out that African Americans diagnosed with schizophrenia are more likely to be prescribed higher doses of neuroleptics (Osiezagha, Barker & Bailey; in press). Prior to the Civil Rights Era, schizophrenia was conceptualized as a mental illness primarily affecting the white middle and upper class, and treatment was psychosocial in nature (Metzl, 2009). In the 60’s and 70’s as schizophrenia became increasingly raced as a “Black disease” neuroleptics and ETC replaced psychotherapy and other psychosocial interventions as the primary treatment (Metzl, 2009). This history is crucial for today’s social workers to consider, whether engaged in direct services, policy, advocacy or research.

The purpose of this theoretical study is to examine what has given rise to the dominant medical narrative of the irreversibility of schizophrenia in the United States to understand the ways in which this forecloses on the possibilities for treatment at both a systems level and within the clinical encounter; and to take an in-depth look at three meaning-making approaches to the treatment of schizophrenia with outcomes that challenge the prevailing medical paradigm in the

hopes of raising awareness about these options, all of which hold as a premise the potential for recovery. I then discuss the principles and practices these approaches have in common and conclude with implications for practice.

I am aware that some individuals find that neuroleptics aid their ability to cope with or cure psychosis. Hence the emphasis of this thesis is not to advocate for the eradication of neuroleptics, but to call into question the hegemony of psychopharmacological treatment; to validate the experiences of the many who do not find this approach effective on its own or at all; and to draw attention to other methods that have been found to be effective in an effort to offer individuals options for treatment and/or support that are consistent with their needs and their values.

CHAPTER 2

Methodology

In this chapter I present the conceptual frame of this study and define terminology that will be used. I will identify the methodological biases of this research as well as its strengths and weaknesses as I perceive them.

Conceptual Framework

As noted in the introduction, the purpose of this theoretical study is to examine what factors have contributed to the construction of the dominant narrative in the United States that schizophrenia is an irreversible and biologically-based mental illness, in order to better understand how this forecloses upon the options for treatment for individuals who have received this diagnosis. The study goes on to explore the method and efficacy of three meaning-making approaches to the treatment of schizophrenia, all of which are founded upon the potential for recovery. In the current chapter, Chapter 2, I define the terms used in this study and identify the potential biases of this research. Chapter 3 provides: a discussion of the phenomenon of the dominant narrative of the United States that schizophrenia is a biogenetically-based persistent mental illness, and the ways in which this over-determines limited options for treatment (Hornstein, 2009; NAMI, 2011; NIMH, 2009; Watters, 2010; Whitaker, 2010); a short history of the diagnosis of schizophrenia (Fusar & Politi, 2008; Metzl, 2009; Whitaker, 2010); and an investigation of the role of culture,

racism and capitalism in promulgating this dominant narrative and in shaping ensuing treatment (Bindeman, 1996; Jackson, 2002; Jenkins and Barrett, 2004; Massumi, 1992; McGruder, 2004; Metzler, 2009; Randal, 2008; Read, 2006; Watters, 2010;). Chapters 4, 5 and 6 examine the methodology and outcomes of three approaches to working with individuals with psychosis and/or who are diagnosed with schizophrenia, that honor the patient's ways of knowing and employ a meaning-making stance. Chapter 4 focuses on peer-based groups such as the United Kingdom-based Hearing Voices Network (Bidois, 2012; Corstens et al, 2008; Dillon, 2012; Hornstein, 2009; Johnstone, 2012; Knight, 2009; Longden & Dillon, 2012; May, 2009; Romme, 2012; Romme & Escher, 2010; Romme & Escher, 2012; Romme, Escher, Dillon, Corstens & Morris, 2009; Salem, 2011; Thornhill, Clare & May, 2004). Chapter 5 looks at psychodynamic treatment with particular emphasis on the closely linked interpersonal, phenomenological and intersubjective schools (Rulf, 2003) with attention to the work of Harry Stack Sullivan (Evans, 1996; Kam-shing, 2002; Sullivan, 1962; Sullivan, 1964), Frieda Fromm-Reichmann (Fromm-Reichmann, 1939, 1943, 1947, 1948, 1954, 1958, 1990; Hornstein, 2000; Silver, 2002), Bertram Karon (1989a, 1989b, 1992, 1999, 2003, 2008); Atwood, Stolorow and Orange (2002), and Paul Lysaker (Lysaker & Daroyanni, 2006; Lysaker & Lysaker, 2005, 2011; Stanghellini & Lysaker, 2007). Chapter 6 explores the Open Dialogue approach pioneered in Finland by Jaakko Seikkula (Seikkula, 2002, 2003, 2008, 2011; Seikkula & Arnkil, 2006; Seikkula & Olson, 2003, 2012; Seikkula & Olson & Sutela, 2012). In Chapter 7, I discuss the points of convergence and disjunction of these three approaches with attention to the ways in which they are at odds with the current biologically-based treatment models employed in the United States. The approaches are compared and contrasted through the lenses of power dynamics, relational healing, use of medication, hospitalization and frequency of meetings. The extent to which these three meaning-

making approaches might compliment and inform one another in contemporary treatment settings is discussed and case material is included to further ground this theoretical paper. Chapter 7 closes with implications for social work practice with the aim of offering viable options for support and treatment of individuals who present with psychosis or who have been diagnosed with schizophrenia.

Definition of Terms

Auditory Hallucination. See hearing voices.

Biological Perspective. In this study the biological perspective is taken to mean one that excludes the influence of psychosocial factors in favor of a genetic, morphological and/or brain chemistry-based etiology of schizophrenia. This perspective privileges biologically-based treatment over psychosocial interventions. It is also referred to as the “medical model.”

C/s/x. This acronym stands for consumer/survivor/ex-patient (Estroff, 2004). This term will be used to refer to individuals who have received psychiatric treatment and/or participate in support groups or treatment programs addressing psychotic or decentering experiences. In some cases, I have decided to use this term in favor of the more common referents such as *client*, *consumer*, *patient*, *schizophrenic*, and *symptom-bearer*. Both *client* and *consumer* further entrenches the healing process in the market economy. *Patient* can suggest a medical setting and implies an air of passivity and pathology on the part of the individual seeking treatment. *Schizophrenic* conflates an individual’s identity with a diagnosis with which they may or may not identify. While *symptom-bearer* suggests that having psychotic experiences is not synonymous with being the locus of pathology it also implies that de-centering experiences are pathological, and that there is one objective reality.

Clinicians. I will use the term clinicians to refer to professional mental health workers with advanced degrees in social work, counseling, nursing, psychology and psychiatry who work with c/s/x in individual or group treatment.

Countertransference. The traditional psychoanalytic definition is follows, “The whole of the analyst’s unconscious reactions to the individual analysand—especially to the analysand’s own transference” (Laplanche & Pontalis, 1973, p. 92). For the purposes of this study I will amend it to refer to the whole of the clinician’s conscious and unconscious reactions to the individual at the center of concern.

Delusions. See unusual beliefs.

Dialogic. Dialogism is premised upon the notion of unfinalizability—that there is no ultimate monologic truth to be grasped, but rather an irreducible polyphonic expression of existence (Morson & Emerson, 1990). Bakhtin writes,

Truth is not born nor is it to be found inside the head of an individual person, it is born *between people* collectively searching for the truth, in the process of their dialogic interaction (as translated in Morson & Emerson, 1990, p. 60).

Experience-near. For the purposes of this study, the term experience-near is used to refer to a way of relating to human subjects, in this case c/s/x, in which the provider identifies with rather than others or objectifies the support-seeker and his or her de-centering experiences. Both objectification and identification are understood to be relative terms and not mutually exclusive. For example, a clinician or peer might simultaneously identify with or objectify a support-seeker for whom they are providing services. It is also understood that objectification and identification are on a spectrum, and that there may be a great deal of vacillation in terms of the position of the provider on that spectrum. An experience-near is also related to dialogic rather

than monologic communication where monologic is the imposition of one's truth onto a subjugated other, and dialogic is the endeavor for a multiperspectival understanding of a situation.

Hearing voices. For the purposes of this paper, hearing voices, and the term voice-hearer encompass sounds heard by a given individual that are not heard by others in their immediate vicinity. The sounds are not necessarily voices. Auditory hallucination is a medical term conceptualizing voices as symptoms of an underlying disease that requires treatment and dismissing the expressive significance of the voices or sounds themselves (Hoffman, 2012). The term hearing voices is used rather than auditory hallucinations to affirm the reality of the subjective experience of the voice hearer; to refrain from implying that hearing voices is symptomatic of any underlying disease; and to convey respect for the expressive content of the voices.

Meaning-making approaches. For the purposes of this study, this phrase refers to methods of support and treatment that engage with the content of the individual's de-centering or psychotic experiences and which view these experiences as stemming from either the interplay of nature and nurture or solely to do with intra-psychic and/or spiritual processes. These approaches include but are not limited to the Hearing Voices Network, psychodynamic practice, and the Open Dialogue model.

Medical model. See Biological Perspective.

Monologic. Monologism is conceptualized in contrast with dialogism. Rather than being arrived at in a specific context in a relational exchange, it is conceived of as an ultimate, final and ready-made truth that claims objectivity and universality (Morson & Emerson, 1990).

Objectification. I use this term to refer to reductionist definitions of or ways of relating to human subjects that are associated with the “othering process” and employed as mechanisms of domination and social control. Bindeman writes,

When a psychologist, for example, operating under the authority of a state institution, defines a person's behavior with terms such as "paranoid schizophrenic" or "obsessive compulsive," then the behavior of that person, and sometimes even the whole person, gets placed within a large and complicated system of control (1996, p. 263).

The objectifying discourse of medical diagnosis exemplifies monologic discourse.

Peers. Synonymous with c/s/x in this paper, unless otherwise specified, this term will be used to refer to c/s/x who provide support for others through some formal body such as the Hearing Voices Network, NAMI, warm lines, etc. Peers may be volunteer.

Psychosis. The definition of psychosis is to a large extent theory-bound. Freud’s view of psychosis is “a rupture between the ego and reality...leaving the ego under the sway of the id,” whereby rejection of reality is achieved by constructing “a new reality in accordance with the desires of the id” (Laplanche & Pontalis, 1973, p. 372). Postmodern theorists and many c/s/x would contest this definition’s premise that there is such a thing as reality (Bindeman, 1996; Deleuze & Guattari, 1972; Hornstein, 2009). For the purposes of this paper, psychosis is at times used as shorthand to refer to experiences of hearing voices, seeing visions and having unusual beliefs.

Schizophrenia. For the purposes of this study the meaning of schizophrenia will depend upon the context in which it is used. The DSM IV definition of schizophrenia is as follows:

Schizophrenia is a disorder that lasts for at least 6 months and includes at least one month of active-phase symptoms (i.e., two [or more] of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms).

Definitions for the Schizophrenia subtypes (Paranoid, Disorganized, Catatonic, Undifferentiated, and Residual) are also included... (American Psychiatric Association, 2000, p.312).

When utilized in the context of postmodern theory, the term will be used to signify the experience and process of de-centering initially formulated by Deleuze and Guattari (1972).

Unusual beliefs. Rather than utilize the term delusion which asserts an objective truth, the term unusual beliefs are understood to be “meaningful and symbolic, they are not merely the bizarre misfirings of a faulty brain” (May, 2012, p. 141).

Strengths, Limitations, and Biases of this Study

Strengths of this study include that it is: 1) grounded in literature written by and for individuals who have experienced psychosis firsthand; 2) it considers psychosis from multiple perspectives including philosophy, anthropology, sociology, history, psychology, biology, and personal narrative accounts; 3) it uses both a micro and macro lens to examine conceptions of schizophrenia and approaches to treatment.

This research has been conceptualized from a social work perspective, and as such, attempts to honor the distinct and varied subjectivities of individuals diagnosed with schizophrenia and/or experiencing psychotic symptoms. It is premised upon the healing power of co-constructing meaning and being heard. Furthermore, rather than locating pathology solely within the individual, the social work frame encourages us to view the phenomenon of

schizophrenia as one of the complex interplay between internal and external forces (Berzoff, Flanagan & Hertz, 2011).

Although I am able to see the role of culture in conceptualizing of psychosis to some degree, my vision continues to be shaped by my own cultural context and socioeconomic status. I clearly place great value in taking a meaning-making stance in relation to mental distress. I believe that neurobiology will offer the most to our understanding of the human experience when it is seen as a part of rather than the whole of our experience. As a clinical social work student, I continue to have an investment in professionals having a role in offering support to those in mental distress. The meaning-making approaches to psychosis that are explored in this paper are each supported by an evidence base that suggest that psychosocial support is a larger predictor of recovery than treatment that privileges pharmaceutical interventions (Evans, 1996; Karon, 1999; Karon & Vandenbos, 1981; Romme et al., 2009; Seikkula, 2004; Whitaker, 2010).

However, evidenced based practice is a loaded term that privileges its own ways of knowing. In order for a practice to be “evidenced-based” it must be manualized, have control groups, and be replicated. However, just because an approach to treatment cannot be manualized does not mean it is less effective. Nowotny, Scott and Gibbons argue that

Striving for valid knowledge through purifying it from its contexts produces *less* valid knowledge than strongly contextualied research (as cited in Seikkula & Arnkil, 2006, p. 177).

For the purposes of this study, I have not focused on Supportive Education or other vocationally focused treatment programs. However, such programs are often an integral component of the Open Dialogue and peer-based models. Nor does this paper address the

successes of Assertive Community Treatment, Soteria (Mosher & Hendrix, 2004) or the Jungian influenced approach of Diabasis (Perry, 2005).

I would also like to note that my relative inexperience as a clinician is both a strength and limitation of this study; as are my firsthand experiences. In my role as a social work student working on the inpatient psychiatric unit of the primary hospital in a small New England state, I was dismayed by the lack of thoughtful and productive treatment we were able to offer individuals diagnosed with schizophrenia, both during their hospital stay, and in developing a suitable discharge plan. Medication was the chief intervention offered. Time and time again I was instructed not to spend time with individuals with psychotic symptoms until their medication had “kicked in,” and never to talk with them about their “delusions” as this would only further entrench their disordered thinking. The state’s day treatment programs were geared towards addressing depression, anxiety, and substance abuse. None accepted individuals with psychotic symptoms. When assisting patients with discharge planning it was a tremendous challenge to find individual therapists who were willing to work with individuals diagnosed with schizophrenia. In my second year placement, at an outpatient clinic, I was again steered away from working with individuals who had psychotic symptoms. As a student, I have been quite frustrated by how difficult it is to find mentors who are able and willing to instruct me in effective ways of providing therapy to individuals experiencing psychosis. In contrast with these experiences, thanks to the support of a skilled psychodynamic therapist, I have effectively been able to address experiences commonly called psychotic without the use of neuroleptics.

While this study may at times polarize biological and meaning-making approaches to treatment of schizophrenia, this is not my intention. It is not possible to separate the mind from the body. Schizophrenia, as defined by the DSM IV, is an association of symptoms. In any given

individual, this association of symptoms may stem from numerous causes and conditions, some of which may be biological in nature, such as genetic predisposition; and some of which may be psychosocial in nature, such as a trauma that triggered the genetic predisposition. It is precisely because there is so much diversity in both the expression of and definition of psychosis, and its development, that it is important to remind ourselves that there may not be one universal etiology, and therefore, there should not be one universal approach to addressing it.

Therefore, the aims of this study are: 1) to deconstruct the dominant biologically-based narrative of the irreversibility of schizophrenia by examining how this narrative came to be; 2) to demonstrate how this narrative and the factors that have contributed to it act as barriers to care for individuals diagnosed with schizophrenia and/or who seek support in coping with experiences of psychosis; 3) to challenge our unwillingness to listen on an individual, cultural and political level as it manifests in the clinical countertransference, in the widespread lack of adequate service provision, and in our propensity to over-medicate the messenger; 4) to thicken current understanding of the diagnosis of schizophrenia; 5) to raise awareness of the efficacy of meaning-making approaches to treatment; and 6) to reflect on implications for practice.

In this chapter, I have discussed strengths, limitations and biases of this study, as I perceive them. I have also outlined the conceptual framework of this research. In Chapter 3, I proceed to examine the phenomenon of the dominant discourse of the irreversibility of schizophrenia.

CHAPTER 3

The Social Construct of Schizophrenia

This chapter addresses the construct of the diagnostic category of schizophrenia and those factors that have contributed to the dominant narrative of schizophrenia as a degenerative and irreversible biological illness. Schizophrenia is not a fact, it is a construct, and as such, it is a slippery one (Boyle, 2012; Foucault, 1976; Szasz, 2011; Laing, 1960). To state that schizophrenia is a construct is not to dismiss or to diminish the experiences of individuals who have been diagnosed with schizophrenia, nor the experiences of those who are close to them. It is simply to say that schizophrenia is a way of explaining behavior that departs from social norms and of categorizing people according to agreed-upon behavioral criteria that may or may not be useful in assisting those who have been diagnosed. The purpose of examining the history of schizophrenia is to better understand the way in which such a construct may both inform and obscure current thinking about what mental illness is, and how best to support those individuals diagnosed with such illnesses.

The Western diagnostic category of schizophrenia has been shaped by a longstanding debate regarding the etiology of mental illness and initially questioned whether mental illness was caused by biology or possession by the devil; and in the West (Boyle, 2012), recast as nature versus nurture. This debate and the economic, cultural and social concerns that have influenced the formation of schizophrenia as a diagnostic category have a direct bearing on clinical practice.

If a policy-maker or clinician conceives of schizophrenia as a biological illness with an inevitably chronic course, the programs and treatment will differ tremendously from those offered by policy-makers and clinicians who understand it to be a psychological response to trauma that can abate with treatment. Hence, treatment and policy might differ further if behaviors associated with schizophrenia were understood as within the range of normal human experience (Bidois, 2012; Corstens et al., 2008, Evans, 1996; Hoffman, 2012; May, 2012).

History of the biological vs. psychological debate and the rise of the narrative of irreversibility

In Western Europe and North America and prior to the rise of industrialization, madness and social deviance were understood as spiritual and moral ailments and for the most part, handled within the purview of the family or local community (Boyle, 2012). Industrialization forced the question of what to do with those who could not support themselves, and shifted responsibility for social deviance and mental illness to the state (Boyle, 2012). It was argued that this shift necessitated the definition of mental illness and professionalization of how to address it, and that the profession of psychiatry emerged with the move to separate those who were labeled as insane from other social deviants (Boyle, 2012; Foucault, 1976). By the early 19th Century, asylums were widespread and were structured in accordance with the philosophy of “moral management” and prescribed work and prayer as the remedy for mental illness. Although clergy were often at the head of these institutions, as it was a pragmatic rather than a technical discourse, it did not require an expert classification. Psychiatrists, however, were able to provide both moral management and medical treatment, while clergy could only offer the former (Boyle, 2012). Some have suggested that to secure the market for the treatment of those deemed insane,

it was in the interest of psychiatrists to claim expert status, which they did by constructing a scientific discourse of mental illness (Boyle, 2012).

With psychiatrists at the helm of state-run asylums, inmates were staying in treatment for longer periods of time. Physician-administrators founded professional journals promoting the view that insanity was due to brain disease and that because it was beyond the patient's capacity to behave rationally, insanity could not be cured by rational means of reward and punishment. This led to the view that medical intervention was necessary. Called 'alienist' by the rest of the profession, psychiatry was segregated from mainstream medicine, as inmates of the asylum were segregated from the general public (Boyle, 2012, p. 37). Looked down upon by the rest of their profession and in an attempt to legitimize themselves, asylum doctors chiefly employed somatic treatments, going so far as to study the brains of deceased patients in built-in laboratories. Whether psychiatric classification schemes should be based on etiology or most prominent symptoms was a vigorous subject of debate. This paved the way for German psychiatrist Emil Kraepelin, author of *Compendium der Psychiatrie*, who believed that schizophrenia has a deteriorating course due to which mental function continuously declines.

Kraepelin and Bleuler

Emil Kraepelin (1856-1926) is often credited as the founder of modern psychiatry, psychopharmacology and psychiatric genetics. His *Compendium* established the classification systems still utilized by the *Diagnostic and Statistical Manual* (DSM) produced by the American Psychological Association and the International Classification of Diseases (ICD). Kraepelin rejected moral, spiritual and psychoanalytic explanations of mental illness as unscientific, and dedicated his career to promotion of the view that mental illness is biological in nature.

Kraepelin was a proponent of eugenics, racial hygiene, Social-Darwinism, and concerned with saving the German 'Volk' from degeneration of the race, using the Jews as an example (Engstrom, 2007). It has been argued that Kraepelin relied upon the paradigm of genetic degeneration to formulate the nosological system of psychiatric illness set out in *Compendium* (Brune, 2007).

From his studies of asylum inmate records, Kraepelin formulated the constructs of manic depression and dementia praecox (Fusar & Politi, 2008). Dementia praecox, the blueprint upon which the concept of schizophrenia was based, was characterized as degenerative and irreversible while manic depression was described as intermittent with periods that were symptom-free. In 1908, drawing on Kraepelin's work and his own clinical observations, Paul Eugen Bleuler coined the term schizophrenia to have an adjectival way of describing those patients thought to suffer from "splitting of the psychic functions" (Boyle, 2012, p. 64); and to denote a distinction between psychosis that was understood to be a result of dementia, and therefore, inevitably degenerative, and psychosis from which it was possible to recover (Fusar & Politi, 2008). Bleuler was also the first to draw a distinction between positive and negative symptoms that are still in use today (Fusar & Politi, 2008). It is important to note that Kraepelin and Bleuler's diagnostic criteria for dementia praecox/schizophrenia were developed based on the observation of patients, many of whom would now be seen by neurologists rather than psychiatrists, and would likely be diagnosed with an illnesses such as post-encephalitic Parkinsonism (Boyle, 2012).

Scientific Critique of the Diagnostic Category of Schizophrenia

The "scientific critics" of the diagnostic category of schizophrenia such as Cromwell,

Bentall, Boyle and Sarbin, contend that in claiming scientific authority, psychiatry must follow its own rules of: 1) observing a meaningful pattern of phenomenon that seem to be associated with one another, 2) demonstrating that this pattern is associated to an independent variable which can be measured in an empirical manner and that have resulted from an “antecedent biological event” (Boyle, 2012, p. 141; Poland, 2007). Boyle argues that Kraepelin’s concept of dementia praecox upon which Bleuler’s concept of schizophrenia is based, was not arrived at by a scientific method (2012). Rather than beginning with presentation of evidence in support of the concept, he wrote as if the concept had already been validated, and he was just reflecting on specific cases rather than establishing and justifying the syndrome itself. Interestingly, Kraepelin never reported the number of people who conformed to his descriptions of symptoms that were 356 pages long and were often vague in nature such as ‘feeble-minded’, ‘weak-minded’, ‘idiocy’, and ‘degeneration’ (Boyle, 2012, p. 56). Like Kraepelin, Bleuler believed that schizophrenia was caused by organic brain disease, but neither proved this, nor distinguished between those behaviors thought to derive from brain disease and those that did not. The “scientific critics” have found Bleuler’s diagnostic criteria to be as vague and subjective as Kraepelin’s, examples of which follow:

unspecified styles of writing or playing the piano; a ‘will o’ the wisp’ gait; pupillary disturbances; the overall impression (unspecified) received from the inmate and the inmate’s remaining ‘quantitatively and qualitatively rigid with regard to the same feelings, even though he response to ideas of varying values’ (Boyle, 2012, p. 68).

Bleuler also noted that ‘schizophrenics took longer to get into the party mood’; that in the upper classes it was typically the wife who is ‘schizophrenic’, as evidenced by nagging, incessant criticizing, irresponsibility and meanness (Boyle, 2012, p. 69); and that he could diagnose

schizophrenia by such factors as gait, dramatic weight fluctuations, excess urination and salivation, and cyanosis of the hands and feet (Boyle, 2012). Boyle concludes her rigorous examination of Kraepelin and Bleuler's work as follows:

To talk of misdiagnosis requires accurate diagnosis, which in turn requires researchers' prior observation which Kraepelin and Bleuler were supposed to make but did not, and which therefore renders nonsensical any arguments about misdiagnosis or diagnosis, of schizophrenia or dementia praecox. If Kraepelin and Bleuler did use phenomena from which we would now infer post-encephalitic Parkinsonism, as part of a putative pattern said to justify the introduction of dementia praecox, then, if these are removed, it must be demonstrated that the remaining phenomena form a pattern which justifies inferring a new construct. This rule is central to the construction of scientific theories. It is clear from Kraepelin and Bleuler's writings that neither the separation nor the demonstration was even attempted, far less achieved (2012, p. 75).

According to the scientific critics of the concept of schizophrenia, such a 'separation' and 'demonstration' has not been undertaken to this day, and as such, the DSM and ICD diagnostic criteria continue to follow the pattern set by Kraepelin by presenting diagnostic criteria for an existing concept rather than the other way around.

Negative symptoms.

The DSM IV work group argued that negative symptoms of schizophrenia should be emphasized by the diagnostic criteria because Kraepelin and Bleuler had done so 100 years ago when they were primarily relying on the records and clinical observation of patients who would most likely now be diagnosed with post-encephalitic Parkinsonism (Boyle, 2012). Other

problems with using negative symptoms as diagnostic criteria include: 1) negative symptom scales have been defined inconsistently leading to difficulty in uniformity and reliability of measurement; 2) negative symptoms are characteristic of other disorders in addition to the diagnosis of schizophrenia making it difficult to parse out whether they are emblematic of Schizophrenia or of some other disorder; 3) it is questionable whether negative symptoms are attributable to schizophrenia itself or to clinical settings, neuroleptics or environmental factors; 4) that negative symptoms were more commonly found in schizophrenia than positive symptoms may suggest that negative symptoms are not in fact characteristic of schizophrenia (Boyle, 2012). It has also been argued that the emphasis on poor outcomes as a signifier of schizophrenia further reflects the circularity of diagnostic criteria: lack of persistence influences employment status and social isolation and these influence affect (2012).

Genetic Predisposition.

Kraepelin and Bleuler advanced the idea of genetic predisposition for schizophrenia before they had technology to test this theory. Current mainstream medical discourse in the United States claims that genetic predisposition for Schizophrenia has been substantiated through adoption, twin and genetic linkage studies. However, many of these studies have been found to be quite problematic with contrary evidence dismissed and discarded, lack of diagnostic consistency, difficulty controlling for nature versus nurture, and lack of blindness of the investigators towards the zygosity of twins. The diagnostic criteria utilized in the studies were so general that the meaning of concordance between twins who met it was undermined. Studies of twins separated at birth did not account for the influence of pre-natal experience, or allow for the likelihood that monozygotic and dizygotic twins would have different experiences, and would be reacted to differently by their environments based on similar and dissimilar appearances. This

suggests that environmental factors may play a pivotal role in why monozygotic twins would act similarly, not just genetics (Boyle, 2012).

Karon cites numerous adoption studies that point to communication patterns in the adoptive family rather than genetic linkage as predictors of schizophrenia (2003), concluding:

The most impressive genetic experiment was one no sane researcher would have carried out (Binder, 1938; Breggin, 1994; Proctor, 1988). For several years all schizophrenics in Nazi Germany were sterilized. Then the annihilation gas chambers were designed by psychiatrists, originally not for Jews, but for mental patients. Hundreds of thousands of schizophrenics were annihilated. But a generation later, the rate of schizophrenia was not affected (see, for example, Haefner and an der Heiden, 1997) (Karon, 2003, p. 13).

Eco-epidemiology.

Researchers aligned with the school of eco-epidemiology postulate that schizophrenia may develop from the complex interplay of the psyche, environment and genetic predisposition, arguing that environmental factors may alter gene expression and increase susceptibility to psychosis (Kirkbride & Jones, 2011; Ross, 2009). Salient environmental factors associated with the onset of schizophrenia include belonging to a visible immigrant group that experiences discrimination, belonging to an ethnic group that is socially fragmented, residence in a neighborhood with low levels of social capital, and urbanization (Kirkbride & Jones, 2011).

“Socioenvironmental disadvantage” is another term that has been used (Kirkbride & Jones, 2011, p. 264) to denote risk factors for schizophrenia, including but not limited to exposure to childhood trauma, “bullying, discrimination, familial discord, substance misuse, social isolation and fragmentation, and factors allied to socioeconomic factors such as employment, education, and income” (Kirkbride & Jones, 2011, p. 264); as well as “environmental insults beyond the

social sphere such as (pre-natal) malnutrition, influenza, hypovitaminosis D, and (proband) substance misuse, which may have their biological effects on psychosis risks more directly” (Kirkbride & Jones, 2010, p. 265) as well as environmental toxins such as air pollution (Ross, 2009; Pederson, 2004) and radiation (Imamura et al., 1999).

Brain chemistry.

While the eco-epidemiologists allow for the complex interplay of nature versus nurture, the biological explanation of schizophrenia is currently the dominant narrative of Western psychiatry. Literature produced by NIMH for the layman emphasizes genetics, brain size and brain chemistry with the slightest of nods toward nurture attributing schizophrenia to:

an imbalance in the complex, interrelated chemical reactions of the brain involving neurotransmitters dopamine and glutamate...many environmental factors may be involved, such as exposure to viruses or malnutrition before birth, problems during birth, and other not yet known psychosocial factors (NIMH, 2009, p. 7).

Literature produced for lay-consumers by the National Alliance for the Mentally Ill (NAMI) describes schizophrenia as a biologically-based disease that *requires* pharmaceutical interventions (NAMI, 2011). It is worth noting that while NAMI presents as a grassroots consumer advocacy organization, and does have a grassroots component, it is primarily funded by the pharmaceutical industry (NAMI, 2012; NAMI, 2010; Grohol, 2009; Harris, 2009). Researchers investigating the efficacy of anti-psychotics have found: 1) no evidence that they improve long-term schizophrenia outcomes; 2) that they may in fact worsen long-term outcomes; 3) that they may increase patients’ vulnerability to psychosis over the long-term and create withdrawal-related risks; 4) that those patients who have not been treated with neuroleptics have higher long-term recovery rates; 5) that anti-psychotics

induce global brain dysfunction in a high percentage of patients over the long-term... cause morphological changes in the brain... associated with a worsening of both positive and negative symptoms, and with cognitive impairment as well (Whitaker, 2010, p. 118-120).

While some researchers have suggested that differences in brain size and gray matter are evidence of the biological etiology of schizophrenia (NIMH, 2011), critics suggest that it is the use of neuroleptics that creates the disparity in brain size between those who have been diagnosed with Schizophrenia and those who have not (Whitaker, 2010; Bolye, 2012).

An evidenced-based critique of the diagnosis of schizophrenia.

Dutch psychiatrist Marius Romme reminds us that the phenomenon of hearing voices has been documented by the ancient civilizations of Egypt, Rome, Tibet, Babylon and Greece. Figures such as Jesus, Socrates, Mohamed, St. Theresa, Joan of Arc, Ghandi, Rilke and Blake were all voice hearers. Why is it that in Western societies hearing voices has come to be conflated with mental illness, and more specifically, with schizophrenia (Romme, 2009).

Romme writes:

There has been a growing tendency to reduce mental health problems to symptoms of disease, rather than reactions to problems in the patient's life. The basic assumption of the 'clinical' psychiatric approach is the existence of a specific disease that leads to symptoms, including voice hearing and experienced as an illness: illness being the subjective experience of disease. This disease is called 'schizophrenia' and, with the development of psychiatric thinking, hearing voices has become linked to this disease...It is argued that voices are, [like the symptoms of diabetes], an illness experience arising from the 'disease' of schizophrenia. The difference is that with diabetes we know what causes the symptoms... In schizophrenia this is not the case since no one really knows

the cause of the disease, so symptoms such as hearing voices are neither logically nor understandably related to that disease. However, in the absence of other evidence about the origins of voice hearing, this idea of the experience being caused by the ‘disease’ has been kept alive (2009, pp. 23-24).

Four percent of the Western population meets criteria for experiencing auditory hallucinations (Tien, 1991; Eaton et al., 1991; Bijl et al., 1998; van Os et al., 2001; Johns & van Os, 2001). Two thirds of those who hear voices neither receive nor indicate the need for mental health care services, and for the most part utilize their voices as advisors to negotiate life’s daily challenges or “with personal problems of an existential type” (Romme, 2009, p. 24). From this, Romme concludes:

These epidemiological studies underpin the ideas that hearing voices is not in itself a sign of psychopathology but rather a signal of other problems, and that identifying hearing voices with a mental disease, especially schizophrenia, is not only scientifically wrong but also harmful... (2009, p. 24).

Qualitative (Ensink, 1992; Romme & Escher, 1989, 1996, 2000) and epidemiological (Read, J., van Os, J., Morrison, A.P. & Ross, C. A., 2005) researchers have pointed to a causal relationship between trauma and distressing experiences of voice hearing evidenced by 70% of patients who are voice hearers (Romme, 2009). From their literature review of 180 studies Read et al. conclude:

Symptoms considered indicative of psychosis and schizophrenia, particularly hallucinations, are at least as strongly related to child abuse and neglect as many other mental health problems. Recent large-scale, general population studies indicate the relationship is a causal one, with a dose effect (2005, p. 1).

In the 50 stories of recovered offered in *Living with Voices* (Romme et al., 2009), voice hearers recount aspects of conventional psychiatric care as informed by the disease concept of schizophrenia have been harmful rather than helpful such as: 1) the conflation of hearing voices with a diagnosis of schizophrenia; 2) iatrogenic effects of hospital admission; 3) the hopelessness of a diagnosis of chronic illness; 4) the patient constructed as the passive receiver of treatment; 5) psychiatric diagnosis eclipsing other life problems; 6) “schizophrenia as a lifelong label” (Romme et al., 2009, p. 27); 7) lack of interest in the content or subjective experience of psychosis; 8) rejection of subjective experience; 9) when medication is found to be ineffective no alternatives are offered; 10) medication resulting in “social breakdown” (Romme et al., 2009, p. 27); 11) the disease concept eroding the alliance between the voice hearer and the professional; 12) reinforcing the societal belief that voice hearing signifies madness; and 13) social ostracism as a result of receiving the diagnosis of schizophrenia (Romme et al., 2009).

Western Meaning-Making Approaches to Psychosis

The Kraepelinian view of schizophrenia as brain disease (whether chemical imbalance or genetic predisposition) currently favored by the mainstream medical institutions of the United States is an ontological approach, conceptualizing of schizophrenia as qualitatively distinct from normal human experience where the capacity to feel or have a subjective experience of the self is absent (Jenkins, 2004). In contrast, the positivist view suggests that schizophrenia is characterized by feelings associated with normal human processes that are experienced far more intensely:

the ordinariness of schizophrenia is revealed through attention to patients’ most vexing personal issues, arguably little different than those of their non-afflicted counterparts:

How can anyone love me? Why would I love anyone when all it means is torture? What can I do in this life? Where is my hope that relief is in sight, that my pain and suffering will end (Jenkins, 2004, p. 31)?

Psychoanalysis.

The Kraepelinian view of Schizophrenia has not always been dominant in the United States. In fact, it wasn't until the adoption of the DSM IV that psychoanalytic language describing psychological processes was entirely replaced by a discussion of associated laboratory and physical examination findings and general medical conditions (Jenkins, 2004, p. 35). Psychoanalysis locates the psychology of psychosis within the individual suggesting that it occurs when the conscious mind is overwhelmed by the unconscious (Dehing, 1994; Dixon, 2005). However, there is a long-standing divide in the psychoanalytic tradition itself about whether or not this method of treatment is amenable for individuals with psychotic symptoms. Freud, for instance, believed it was not (Silver, 2002). Nonetheless, prior to World War I, a growing number of psychiatrists and analysts in the United States were treating psychotic patients with traditional psychoanalytic techniques (Silver, 2002). Edward Kempf, employed by St. Elizabeth's psychiatric hospital in the District of Columbia was one of these, and developed "active" as opposed to passive psychoanalysis, laying a foundation for the relational work of Harry Stack Sullivan, Wilfred Bion and Frieda Fromm-Reichmann (Hornstein, 2009; Dehing, 1994; Silver, 2002). In the 1930s, at Maryland's Sheppard Pratt Psychiatric Hospital, Sullivan claimed an 85% recovery rate for patients with Schizophrenia (Hornstein, 2000).

Frieda Fromm-Reichmann, who began her psychiatric career in Germany managing an asylum for WWI veterans, believed as did Sullivan, that all human beings exist within a relational framework, making transference possible; and that psychosis, rather than an arbitrary

brain malfunction, was a form of communication. She understood psychosis as terror that had not been verbalized. Whereas WWI veterans might talk about the combat-related events that continued to trouble them after the war, early childhood trauma was all the more difficult to verbalize within the context of the family. Feelings of rage and terror that were repressed during childhood endangered the child's capacity to form relationships in the future (Hornstein, 2000).

Reichmann, Sullivan, Ferenczi and others associated with the interpersonal school of psychoanalysis viewed the relationship with the therapist as a corrective emotional experience, privileging the experiential quality of the therapeutic relationship over the interpretive emphasis of more traditional therapy. For example, Sullivan and Reichmann might sit beside rather than behind the patient, and focus on engagement rather than free association (Hornstein, 2000).

With the advent of managed care and its subsequent erosion of inpatient and residential psychiatric facilities, psychosocial modes of treatment for schizophrenia have become both logistically compromised and professionally blacklisted. Psychodynamic treatment of schizophrenia has been particularly targeted. Silver notes that in 2002, many in the leadership of The International Society for the Psychological Treatment of Schizophrenia and other Psychoses (ISPS) advocate cognitive behavioral interventions and consider psychoanalytic approaches to be "dangerous" (Silver, 2002, p. 12).¹ However, contemporary intersubjective psychoanalysts in the United States argue that their post-Cartesian viewpoint allows the validation of the patient's

¹ In March 2012 ISPS voted to change its name to the International Society for Psychological and Social Approaches to Psychosis in acknowledgement of the lack of scientific validity of the diagnosis of schizophrenia. ISPS Chairperson Dr. Brian Martindale:

This significant change reflects the ISPS's determination to persuade mental health services to provide high quality psychological interventions for users and families when psychosis is involved. We need to move on from the stigmatising and false idea that schizophrenia is a single identifiable biologically determined 'disease' (Martindale, 2012).

Other organizations in Japan, UK and New Zealand have gone through a similar name-changing process.

construction of reality in contrast to cognitive behavior therapy or traditional psychoanalytic framework founded on the Cartesian principle that there is one universal reality or truth; and therefore offers the patient who experiences a sense of annihilation the opportunity to be authentically heard and known by the therapist, which may gradually restore their sense of being (Nelson et al., 2008; Atwood et. al., 2002; Parnas and Sass, 2001). The interpersonal and intersubjective schools' approach to psychosis will be explored in greater detail in Chapter 5.

Jungian conceptualization of psychosis.

Jung conceptualized schizophrenia as a natural healing process and a visionary experience where necessary madness “comes in overwhelming strength” and may be seen as a spiritual emergency (Perry, 2005, p. 14). In Jung's view

Archetypes are defined as instinctive, innate predispositions to form images along certain universal lines. They are the natural modes of thought of the archaic mind either in primitive mentality, or in the primitive level of the modern mind... Psychosis, then, in this view is an irruption of these symbolic, archetypal images and processes into the field of consciousness, like an ocean bursting its dykes and flooding the land. But though it seems as chaotic as a flood, it actually is not entirely so, and threads of order may be discerned by the practiced eye. If the symbols are not disregarded as mere lunatic delusions, but are noted with care, they are found to represent the essence of the psychotic process, and even in the fortunate cases are found to point to a healing process. But they must be taken as meaningful if such a process is to reach its goal (Perry, 1956, p. 55).

The grandiose messianic and heroic imagery common to these experiences can be understood as the need to redeem and renew the internal world, as well as the need to revision the shared world

(Perry, 2005). Psychosis, then, is a regressive process in the service of rebirth where the “therapeutic relationship becomes a new matrix in which this entire reconstitution of the self may take place” (Perry, 1956, p. 65).

Bateson and the double bind theory.

Anthropologist Gregory Bateson’s work on the double-bind theory of Schizophrenia grew out of an interdisciplinary research group organized by Reichmann during a year-long fellowship in Palo Alto where she had planned to write up the case of the Joanne Greenberg, author of the autobiographical novel *I Never Promised You a Rose Garden*. The double-bind theory posited:

that the ‘victim’—the person who becomes psychotically unwell—finds him or herself in a communicational matrix, in which messages contradict each other, the contradiction is not able to be communicated on and the unwell person is not able to leave the field of interaction...he or she will live in a world of disordered messages, where active and appropriate deciphering will be experienced as dangerous, and possibly only known, as a nameless, felt perpetual angst (Gibney, 2006, p. 50).

Bateson’s perspective ascribes logic to psychotic expression:

That is to say, he must live in a universe where the sequences of events are such that his unconventional communicational habits will be in some sense appropriate (Bateson, 1972, p. 206).

Bowen Family Systems.

Bateson’s initial work on family communication systems was further developed by psychiatrist, Murray Bowen, who developed family systems theory in response to

working with those diagnosed with Schizophrenia and their families. Bowen understood the patient's illness as a

symptom of a relationship process that extends beyond the boundaries of the individual 'patient.' This relationship process is anchored in the family emotional system.

Schizophrenia is a disorder of the family emotional system (Bowen & Kerr, 1988, p. 237).

According to Bowen Theory, the symptom-bearer experiences almost no separation between herself and the parent, resulting in a high level of chronic anxiety and emotional reactivity to the perceived needs and demands of others. Psychotic symptoms are mobilized by the patient to create an internal boundary, insulating herself from her own feelings and from the feelings of others in the attempt to maintain emotional equilibrium within the self and between the self and the environment. The process that gives rise to schizophrenia is understood to be multigenerational, occurring over 75-250 years during which there is a gradual erasure of the self, leading to lower levels of differentiation in each successive generation. Bowen theorists postulate that the anxiety of the symptom-bearer has originated in the larger family system, and that by absorbing this anxiety, the symptom-bearer enables the family as a whole to maintain its equilibrium (Bowen, 1988). Rather than attributing schizophrenia to a defect located in the individual, Bowen theorists suggest that the "emotional process in the human species generates schizophrenia" (p. 337), and that it is the multigenerational family process that has produced the anxiety as well as the symptoms expressed by the symptom-bearer. By conceptualizing of human functioning on a continuum, with schizophrenia on one end of the continuum, Bowen Theory eradicates the dichotomy between "normal people and defective people" (p. 254); understanding schizophrenia to reside in every individual and every family.

R. D. Laing.

R.D. Laing believed schizophrenia to be an existential dilemma of ‘ontological insecurity’ (Laing, 1960, p. 44) and attributed this loss of personal unity and agency to the impingement of the family on the individual (Matthews, 2007). A psychiatrist himself, Laing rejected the validity of psychiatric diagnostic categories, believing they were based on a false epistemology of diagnosing illness by behavioral criteria and treating it medically (Laing, 1960). Influenced by Canadian sociologist Ervin Goffman, Laing took the focus off the family, and instead, conceived of Schizophrenia as a normal reaction to a mad society, claiming that it was the social ostracism, diagnoses, social structures and the asylums themselves that drove individuals to madness (Laing, 1960; Lambrecht & Taitimu, 2012). In 1965, Laing founded Kingsley Hall, a London-based residential program that eschewed mainstream somatic treatment such as neuroleptics and electro-convulsive therapy (ECT) in favor creating a holding environment, allowing individuals to freely explore their inner world. Like Frieda Fromm-Reichmann’s Chestnut Lodge, in Maryland—the only inpatient program in the US that exclusively offered psychoanalytic treatment to those diagnosed with schizophrenia—patients were allowed to be crazy in the hospital, the point of which was to allow patients to regress in the service of exposure of the psychopathology, rather than struggling to suppress it in the attempt to manage daily life on the outside (Hornstein, 2000). Laing, Reichmann and Sullivan understood psychosis as a natural healing process. However, they differed over the role that professionals ought to play in this process, and in the extent of structure required by those in the throes of this process. Kingsley Hall relied as little upon health professionals as possible, placing administrative and treatment decisions largely in the hands of its residents and nonprofessional staff (Mosher & Hendrix, 2004), whereas interpersonal psychiatrists like Reichmann and

Sullivan, strongly believed in the role of the therapist as co-collaborator in the healing process, and felt that it was important not to offer their patients more freedom and responsibility than they could handle (Hornstein, 2000). During the 1970's, other residential communities were founded that privileged meaning-making philosophies over the biological approach. One of these, Soteria House, drew from the work of the Laing and Sullivan as well as the pre-biological 19th century approach of moral management, favoring non-professional treatment with an emphasis on relationship building and creativity (Mosher & Hendrix, 2004).

Phenomenological psychiatry.

Phenomenological psychiatry offers a rigorous examination of the subjective experience of psychosis as a way of gaining insight into the conditions that have given rise to it (Sass & Parnas, 2007). This tradition of psychiatric inquiry stems from the philosophers Husserl, Heidegger, Merleau-Ponty, and Jaspers. Phenomenological psychiatry conceptualizes schizophrenia as fundamentally a disturbance of ipseity, “a crucial sense of self-sameness, of existing as a subject of experience that is at one with itself at any given moment” (Sass & Parnas, 2007, p. 68). This way of being is comprised of hyper-reflexivity or, an exaggerated self-consciousness as well as disavowing and externalizing internal processes that would “normally be ‘inhabited’ or experienced as part of oneself” (Sass & Parnas, 2007, p. 68). This state is also described by phenomenologists as the absence of experiencing oneself as a unified subject in time and space (Sass & Parnas, 2007; Rulf, 2003). Chapter Five will take a closer look at Lysaker, Daroyanni and Stanghellini, whose work is strongly influenced by both phenomenological psychiatry and intersubjectivity.

Supported education.

Supported education focuses on improving the fit between the individual and their environment from the perspective of the symptom-bearer or student and attempts to engage the consumer, peer advocacy organizations, community mental health centers, families, vocational rehabilitation agencies and institutions of postsecondary education in supporting the student in their pursuit of higher education and realizing their career goals by tailoring programming to their abilities (Mowbray et. al., 2005). Students are involved in the administration and accountability structures of the SEd programs. Rather than accept the dominant narrative that a diagnosis of schizophrenia means a life on SSI/D, the SEd approach expands mental health treatment to include rehabilitation and operationalizes the core values of hope, normalization, self-determination, support and relationships and systems change (Mowbray, 2005).

Open Dialogue.

Open Dialogue takes an overlapping but distinct approach to working with individuals with psychosis, emphasizing the repair of communication breakdown between the symptom-bearer and his or her social network, Open Dialogue seeks to rely on clinical settings as little as possible. In this model, a team of clinicians meets with the “person at the center of concern” (POC), and their social network, in the home of the POC if possible, or in a mutually agreed upon community-based setting if the POC does not wish to meet in their home. If the family or POC feels unsafe, a nurse is made available to assist the family and POC with establishing safety in the home environment. Jaakko Seikkula, a Finnish clinician and researcher who formulated the Open Dialogue approach to treating acute mental illness and psychosis, conceives of Schizophrenia as an impasse of communication in the context of a social network, often in relation to a traumatic experience. In this approach psychosis is thought of as a way of

expressing what cannot be said or thought in conventional language (Seikkula, & Olson, 2003; Seikkula, 2012). Open Dialogue's non-hierarchical model and emphasis on transparency and meaning-making approach is concordant with the values expressed by psychiatric survivors, peer advocates and some mental health professionals who advocate that clinicians learn from psychiatric survivors themselves who have produced an enormous body of literature documenting and interpreting their own experiences of psychosis (Greenberg, 1989; Hornstein, 2009; James, 2001; Lakeman, 2001; Martin, 2000; Romme et al., 2009). Vocational rehabilitation and individual therapy are often enlisted as supports in the treatment, and those who have been treated with the Open Dialogue approach have a higher employment rate than Finland's non-psychiatric patient population (Whitaker, 2010; Seikkula & Arnkil, 2006). The Open Dialogue will be further explored in Chapter 6.

Hearing Voices Network.

The Hearing Voices Network (HVN), introduced to the United States in 2008 by Holyoke College professor Gail Hornstein (McCarthy-Jones, 2010), has some interesting commonalities with the Open Dialogue approach. The Hearing Voices Network is a c/s/x movement that connects individuals who have heard or currently hear voices in a model of nonhierarchical support groups (Hornstein, 2009). In these groups, participants have the opportunity to share their experiences, distress, and coping mechanisms and to reduce their isolation. The Hearing Voices Network has been strongly influenced by the Maastrich Approach, developed in the Netherlands by psychiatrist Marius Romme and Sandra Escher. In their research, Romme and Escher found a higher prevalence of voice hearers in the general population than was previously thought. The insights culled from interviewing hundreds of non-patient voice hearers as to their coping strategies and ways of understanding their experiences have been incorporated into

HVN's model. The Maastricht approach differs from mainstream psychiatry in that the eradication of voices is not the aim. Voices are seen as "meaningful human phenomenon" originating in the history of the individual who was "overwhelmed by emotions in threatening circumstances" (Corstens et al., 2008, p. 331). Both the Open Dialogue and the HVN model privilege: 1) listening to the experiences, psychotic or otherwise, of the identified patient; 2) reducing isolation/building community; 3) non-hierarchical structure of "treatment"; 4) listening without the intent to change which Seikkula refers to as "tolerance of uncertainty"; 5) openness to a range of interventions such as psychodynamic therapy, cognitive behavior therapy, medication, vocational training, no therapy, etc (Seikkula, 2012). These shared qualities of meaning making, community building, transparency, equality, and tolerance of uncertainty resonate with the postmodernist view that schizophrenia arises from and is reified by structures of domination and control (language, capitalism, the medical establishment), isolation (commodification, objectification), and assertion of absolute truth (dominant narrative). The movement and approach of the Hearing Voices Network will be further explored in Chapter 4.

Non-Western Conceptions of Voices, Visions and Non-Conforming Beliefs

While "scientific critics" such as Boyle and Bentall claim the concept of schizophrenia is not valid by scientific standards, "socio-political" critics, such as Foucault, Szasz and Laing emphasize the historical, cultural and economic influences on the formulation of psychiatric diagnoses to call into question the validity of a scientific or medical model, highlighting the ethical and socio-political dilemmas raised by such categories and practices (Poland, 2007).

The postmodernists' contention that schizophrenic process is a disruption of capitalism, industrialization and commodification leads back to the ways in which the diagnosis is culture-bound and the ways in which the symptoms are culturally mediated. Prompted by the WHO's groundbreaking longitudinal studies mentioned above which found that outcomes for schizophrenics in industrialized countries were far worse (59% chronicity) than outcomes for schizophrenics in developing countries (slightly more than 30% chronicity), anthropologist Juli McGruder conducted ethnographic research in Zanzibar to further examine the ways in which the diagnosis and symptom expression is culturally constructed and culturally mediated. One of McGruder's primary findings (2004) was the ways in which the diagnosis of schizophrenia "others" the individual who is expressing these symptoms, influencing the family and medical providers to objectify the symptom-bearer. McGruder pointed out that Western culture, so highly values self-control and control of circumstances, we become abject when contemplating mentation that seems more changeable, less restrained and less controllable, more open to outside influence, than we imagine our own to be (McGruder, 2004; McGruder as cited in Watters, 2010, p. 165).

McGruder suggested that in cultures where psychotic symptoms are understood as spirit possession, because spirit possession can be visited upon anyone, "othering" is less likely to take place (Watters, 2010, p. 159). The Western tradition places a high premium on self-determination and personal choice whereas in Zanzibar the prevailing norm is that fate is in the hands of God, not the individual. Families in Zanzibar who viewed illness as a blessing sent by God, offering them the chance to be of service and to dedicate this service to God were more likely to see a remission of symptoms in the identified patient whereas families who began to

ally themselves with Western medicine were more prone to dehumanizing the symptom-bearer and in so doing, contributing to their symptom expression (Watters, 2010).

Castillo argues that cultural beliefs structure the symptoms, experience and interpretation of psychosis (2003). In a study that surveyed ethnographic data from 437 societies worldwide it was found that “trance-induced auditory and visual hallucinations played a role in 89% of the cultures studied” as voluntarily practiced in the context of religious and healing rituals (Castillo, 2003, p. 14). As suggested by McGruder above, pre-modern meaning systems explain psychosis as spirit possession originating outside the patient, directing less hostility at the patient. This non-pathologizing framework, in which psychosis is seen as extrinsic with the possibility of recovery rather than intrinsic, contrasts with Western culture’s intrinsic (brain disease) and incurable (genetic) framework (Castillo, 2003). Castillo writes:

The medical model, then, has the potential of setting up a feedback loop in which environmental stress causes trance behavior, which leads to a catastrophic psychiatric diagnosis, which then leads to more stress, which leads to more trance behavior. In this way trance behavior might become recurrent and habitual, possibly causing long-term alterations in neural circuits underlying trance experience and promoting chronic functional psychosis (2003, p. 16).

Taitimu and Lambrecht identify three categories of literature on culture, subjectivity and psychosis: 1) cross-cultural studies as exemplified by the WHO studies, which examined the prevalence of symptoms of schizophrenia cross-culturally with no attention to the subjective experience of the research subjects in which indigenous beliefs about psychosis were dismissed as misconceptions and superstitions and “spiritual/traditional constructions” were described as “resistant and persistent” (2012, p. 47); 2) transcultural studies in which Western psychologists

discuss culture-bound syndromes with no attention to subjective experience or cultural meanings for consumption by westerners in the process of which much meaning is “whitened” and lost in translation (p. 48); and 3) indigenous studies which are conducted from within the cultural group by members of the group for the benefit of the group itself. This form of research seeks to centralize indigenous ways of knowing and recognize this knowledge as legitimate in its own right without having to ascribe to another body of knowledge for validation (p. 48).

A practitioner of the indigenous model of research herself, Taitimu’s findings have been consistent with Castillo and McGruder’s in suggesting that spiritual constructions of psychotic symptoms lead to better outcomes by contextualizing the experience of psychosis and offering the expectation of recovery whereas the psychiatric constructions are more likely to lead to individuals internalizing the problem and associating it with a chronic course of illness (2012).

Egan Bidois, a Maori mental health researcher and liaison worker ‘with constant lived experiences of psychosis and paranoid schizophrenia’ (2012, p. xii) writes,

I am not by default ‘unwell’ because I hear, see or feel supposed non-apparent stimuli. Rather, the non-apparent stimuli I hear, see and feel *can* effectively drive me into unwellness if not managed appropriately (p. 37).

Bidois makes an important distinction. It is not the voice-hearing, visions or non-conforming beliefs per se that determine illness or health, but the extent to which the individual feels able to manage these experiences and/or the extent to which the individual’s social network has the capacity to be in relationship with them. We will hear more from Bidois in Chapter 4, which takes an in-depth look at the meaning-making approach of the Hearing Voices Network, a model built from voice hearers’ subjective experience.

In their article, “Dissociation, psychosis and spirituality: whose voices are we hearing?”

Randal, Geekie, Lambrecht and Taitimu (2008) echo Jung and Perry in their conceptualization of psychosis as spiritual emergency and a time of profound psychological transformation involving one's entire being and including voices, visions, intensity of emotional experience, other Out-of-the-Ordinary Experiences (OOE's) where spiritual themes may include death and rebirth of the psyche, experiences associated with memory of past lives, oneness of self with the universe, and visitations with mythological or divine life forms. C/s/x "multifaceted explanations of their own experiences" (p. 334) have been shown to have therapeutic worth, and yet are "inherently contestable" (p. 334), and are overwritten by most medical professionals as: presenting with fear, disorientation, auditory and visual hallucinations, delusions, dysregulation and interpersonally compromised. This struggle for authoring between the individual trying to describe their own subjective experience and the professionals engaged in their psychiatric treatment is plays a crucial role in determining the course and outcome of psychotic process/spiritual emergency (Randal et al., 2008).

In Maori culture, OOE's labeled by Western diagnostic criteria as schizophrenia are interpreted as the gift of being a Tohunga or shaman. Some Tohunga work with the mental health system in New Zealand to assist individuals who have received the diagnosis of schizophrenia to mentor them in cultivating and managing this gift so that it doesn't overwhelm or sicken them (Randal et al., 2008). This demonstrates a shift from being a victim of voices/spirits to becoming a master of voices/spirits with training. It invokes a developmental, spiritual, and archetypal journey where guided practice allows one to avoid being tyrannized by the negative spirits and the healing takes place within the spirit world. Once the healer heals the self, they are available to assist in the healing process of others (Randal et al., 2008).

Randal, a practicing psychiatrist, understood her own psychotic break as a spiritual emergency. She too experienced the subjugation of her understanding as she moved through the traditional system of care. She writes,

The stigmatizing of OOE's by the 'voice of psychiatry' within Western contexts has its historical and political roots in the Christianity of the Middle Ages and the prevalent understanding of demonic forces. Colonial powers executed that thousands of witches and sorcerers (also in Europe), and through torture yielded confessions about consorting with spirits and the Devil... (2008, p. 339).

The shaman became 'the *evil* other' making it easier to subjugate indigenous people during Enlightenment, and was recast as the charlatan in contrast to the supreme scientific method. Randal et al. contend that to assist with the missive of colonization, shamans were relegated to the 'ridiculous other' (p. 339), and with the rise of psychoanalysis were recast again as the 'mad other' (p. 340). They suggest that the West has much to learn from non-Western conceptions of altered states of consciousness:

Non-western cultures may have technologies, practices and disciplines that could provide theoretical and practical insights in to ASCs [altered states of consciousness], trance states and spiritual states different from common Western views, and thereby provide new insights into psychotic and dissociative states, if only these cultural 'voices' were allowed to be heard. These insights would allow a move away from psychosis and dissociation being merely understood symptomatically and pathologically (as they are currently in most Western cultures). They might rather be considered dynamically as a transformational process of change in consciousness, over which mastery may be gained by specific teaching methods... (2008, p. 340).

With guidance, individuals may experience a shift from “involuntary disintegrative states to greater levels of personal integration and consciousness” (p. 341). From her own experience, Randal has developed a theoretical model in which when approached in the context of spiritual meaning-making, life crises are opportunities to strengthen the self and to build a “bridge of trust” (p. 342) where the doctor’s truth is not imposed on the client, and the client’s truths are listened to and respected (Randal et al., 2008).

Forces that privilege the biological narrative of schizophrenia over meaning-making approaches to psychosis

“Historically, schizophrenia has focused attention on the bounds of community and the existential limits of what it is to be human” (Lucas, 2004, p. 148). How these lines are drawn is contested territory. Economic, social, political and biological factors influence the construction of culture that dictates what is considered to be human behavior, and culture predisposes us to endorse particular notions of humanity. Kleinman writes:

Illness experience, for the ethnographer, is a moral phenomenon because, like all forms of experience, particular things are most at stake for sufferers and their families.

Schizophrenia, seen in this ethnographic angle of vision, not only has a political economy but a moral economy as well. Values are embedded and have a presence in the symptoms and course of psychosis, but they are also alive in the experiences of caregivers and researchers, so that the entire enterprise of understanding and managing schizophrenia is inseparable from the pull and push of different contested values and the political economy that supports them (2004, p. xvii).

Postmodern critics have long suggested that psychiatry is far from value-free. Though concerned more with strategies of social control and resistance and less with clinical efficacy, postmodernist thinkers anticipated the inter-subjective school of psychoanalysis in calling attention to the ways in which the psychiatric diagnosis of schizophrenia is mobilized in the service of capitalism (Bindeman, 1996; Massumi, 1992; Deleuze & Guattari, 1972; Foucault, 1976) to objectify and silence those who “confront aspects of the world that most of us choose not to notice. The overpowering force of their perceptions, however, may be the source for their lack of control over their obsessive disorders” (Bindeman, 1996, p.264). Here the schizophrenic lens of de-centering is viewed as instructive and necessary in awakening us to our own biases with the recognition that the acquisition of comprehensive or ultimate knowledge is impossible (Bindeman, 1996). The postmodernists further postulate that clinical settings and the concept of clinical detachment are “part of the problem rather than part of the solution” because they attempt to treat the symptom-bearer in a vacuum without reference to the societal and familial factors that played a role in the development of these symptoms” (Bindeman, 1996, pp. 266).

Race, social control and schizophrenia.

Metzl, Jackson and Sadowsky’s work illustrate the ways in which truth is legislated by those in power. Those who are most socioeconomically disenfranchised or considered minors are more likely to have their hallucinations judged pathological by the medical field (Boyle, 2012; Metzl, 2009; Osiezagha, Barker & Bailey, in press). Viewing delusions as beliefs constructed by a subject rather than as a neurological, biochemical or cognitive deficit context and meaning becomes relevant as it would for other “normal” behavior. The biological model of psychosis fails to account for:

variability in hallucinatory experiences: for example, why is *this* thought and not *that*

thought attributed to an external source? Why do many people who hear voices have no difficulty in discriminating the origins of most of their thoughts? What accounts for the intensely self-referential nature of voices? Why should the defect or bias assumed to underlie hallucinatory experiences apparently be more pronounced among Afro-Caribbean men living in Britain or among women in the general population? (Boyle, 2012, p. 253).

Boyle writes, “a delusion only officially comes into being when a speaker and a more powerful hearer disagree about a belief claim” (2012, p. 281). J. C. Carothers, a white colonial psychiatrist in Nigeria reported, “Africans were especially prone to persecutory [delusions]” (Sadowsky, 2004, p. 246). How is it possible to distinguish between persecutory delusions and ‘real’ persecution in a socially stratified racialized society? Vanessa Jackson has written a compelling article detailing the ways in which: 1) African Americans have met with cruel and inhumane practices perpetrated by the US mental health system; and 2) how structural racism has been recast as a pathology of the African American psyche (2002). Psychiatric diagnoses of Drapetomania and Dysaesthesia Aethiopica were used in the United States to pathologize slaves who showed signs of “laziness” or the desire to escape (Metzl, 2009; Jackson, 2002). American physicians Vernon Mark, William Sweet and Frank Ervin claimed that urban violence, which many perceive as a reaction to racial and class oppression was actually due to “brain dysfunction,” and advocated for the use of psychosurgery (lobotomy) to keep the peace (Jackson, 2002, p. 18). Through her interviews with African American psychiatric survivors Jackson noted several trends of both civil rights activism and complex trauma histories. One of the interviewees, Ola Mae Clemons, called the Rosa Parks of Albany, Georgia, was involuntarily hospitalized and diagnosed with paranoid schizophrenia after refusing to sit at the back of the

bus. Interviewees reported that their prior experiences of complex trauma went unaddressed by their mental health clinicians. Rather, they were offered or forced to receive shock treatment, psychosurgery and neuroleptics.

The clarity with which Pearl Johnson speaks of the violence that she experienced throughout her life makes it all the more shocking that a therapist never followed this theme as a source of her depression and substance abuse; it amounts to nothing less than malpractice. The larger issue of cultural violence in the form of the suppression and violation of our civil rights is also ignored in psychiatric literature but is an ever-present reality in our daily lives. How do we address these issues while avoiding yet another psychiatric label? If an entire group experiences symptoms of posttraumatic stress disorder, when does it shift from being an individualized psychiatric disorder to a public health crisis that must be addressed at its root? (Jackson, 2002, p. 18).

In *Protest Psychosis: how schizophrenia became a Black disease*, psychiatrist Jonathan Metzl argues that racism is imbedded in psychiatric diagnostic criteria, healthcare policy, scientific and popular understandings of mental illness, institutional programs and practices. Even as the medical establishment claims that Schizophrenia is a biological disease found in 1% of the population regardless of socio-economic status, Metzl notes that during the 1980s and 1990s medical journals cited that African American men were 5 to 7 times more likely to be diagnosed with paranoid schizophrenia than white men and that African American men were “significantly less likely” to be diagnosed with depression or bipolar disorder than whites (2012, p. xi). In an article published by the *Archives of General Psychiatry* in 1968, Psychiatrists Walter Bromberg and Frank Simon called Schizophrenia a “protest psychosis” developed by African American men who became aggressive, hostile and who espoused “delusional anti-

whiteness” in response to the words of Malcolm X, associating with the Black Muslims or other groups engaged in or advocating organized resistance to white society (Metzl, 2009, pp. xiv).

Metzl goes on to argue that

Schizophrenia’s rhetorical transformation from an illness of white feminine docility to one of black male hostility resulted from a confluence of social and medical forces such as the biased actions of individual doctors, researchers, or drug advertisers, while others functioned at structural levels beyond individual perceptions... Prior to the 1960s psychiatric classification systems often posited that schizophrenia was a psychological “reaction” to the splitting of the basic functions of personality. Official descriptors emphasized the generally calm nature of such persons in ways that encouraged associations with middle-class housewives... In 1968, in the midst of a political climate marked by profound protest and social unrest, psychiatry published the second edition of the *Diagnostic and Statistical Manual (DSM)*. That text recast the paranoid subtype of schizophrenia as a disorder of masculinized belligerence... Growing number of research articles from the 1960s and 1970s used this language to assert that schizophrenia was a condition that also afflicted “Negro men,” and that black forms of the illness were more hostile and aggressive than were white ones (2002, p. xv).

One might look at the language of diagnostic criteria and the societal stereotypes it intentionally or unintentionally evokes as a reflection of the shifting anxieties of the ruling class moving from concern over the role of white women within white upper and middle class society, to concern of being threatened by the increasing demand for equity staked by African Americans.

While cultural critics of the biological model of psychosis have largely focused on the

dominant culture's resistance to acknowledging the environmental factors or power dynamics at play when mental illness is highly associated with disenfranchised groups, race has been mobilized differently to assist whites in keeping their own psychological fragility at bay. A story run on BBC News in 2000 describing the research of Littlewood and Lipsedge suggest that immigrants' mental illness is caused by social and economic conditions, while for nonimmigrant whites it remains a biological illness:

...poor social conditions are causing black people to develop the symptoms of mental illness...although 75% of white patients with schizophrenia had some biological reason for their illness in black patients it was only 25% (Littlewood and Lipsedge as cited in Boyle, 2012, p. 314).

However, in keeping with Kraepelinian roots—even though a gene has not yet been found—most of the current research on race, ethnicity and schizophrenia is focused on genetics rather than social conditions (Boyle, 2012). As long as mental distress is associated with a diagnosis of schizophrenia and is solely considered a problem of chemistry and genetics, it allows physicians and the powers that be to ignore the individual and collective psychic cost of racial and social oppression.

Commercial interests.

The onset of the international studies of schizophrenia in the 1960s conducted by the World Health Organization, which followed research subjects for 25 years, showed those countries with the least reliance on neuroleptics to have the best outcomes for individuals diagnosed with schizophrenia (Watters, 2010; Whitaker, 2010). While this is the case, it is considered to be a violation of standards of care if a psychiatrist refrains from prescribing neuroleptics to individuals exhibiting psychotic symptoms. In *Anatomy of an Epidemic*,

Whitaker examines a host of clinical trials of neuroleptics funded by the pharmaceutical industry. While in some cases neuroleptics were found to have short-term clinical efficacy as compared to the use of a placebo, long-term efficacy was assessed by abruptly taking individuals off the neuroleptics. Abrupt withdrawal, unsurprisingly, resulted in a high rate of relapse. However, the relapse rate for those patients who were gradually weaned off of the neuroleptics was similar to the rate for those who were maintained on the medications. One year later, in a follow-up study, the patients given placebos in the short-term efficacy trials were less likely to have been re-hospitalized than those treated with neuroleptics. Studies also demonstrated that the higher the dosage of neuroleptics, the greater the rate of relapse. McGill University researchers Guy Chouinard and Barry Jones found that neuroleptics increased patient vulnerability to psychosis as it changes the chemistry of the brain. The longer one is on the drugs, the longer it takes for the brain to return to baseline. Eventually however, the increase in D2 receptors that corresponds with tardive psychosis and tardive dyskinesia are irreversible. One can see how the side effects of the neuroleptics would have contributed to the notion that schizophrenia, once diagnosed, is a degenerative and irreversible illness.

The Vermont Longitudinal Study corroborated Chouinard and Jones' hypothesis that the use of neuroleptics increases vulnerability to psychosis over the long term. One hundred sixty-eight patients diagnosed with schizophrenia were interviewed 20 years after their discharge from Vermont State Hospital. Thirty-four percent of those interviewed were recovered as defined by being employed, living independently and engagement in close relationships; and what they all had in common was that they had long since stopped using neuroleptics. The longitudinal studies conducted by the WHO suggest, "In countries where patients hadn't been regularly maintained on antipsychotics earlier in their illness, the majority had recovered and were doing well fifteen

years later” (Whitaker, 2010, p. 111). In the 90s, researchers who set out to use MRIs to distinguish between the brain structure and volume of those with and without Schizophrenia ended up finding that it was exposure to neuroleptics caused the frontal lobes (the capacity to think) to shrink and the basal ganglia to swell, exacerbating the positive and negative symptoms associated with psychosis.

In the 1990s a new generation of neuroleptics, including Resperidol (Resperidone), Seroquel and Zyprexa (Olanzapine), commonly referred to as ‘atypicals’ was brought to market by the pharmaceutical companies with claims of higher efficacy and no side effects. The FDA, citing biased clinical trials, forbade Janssen from advertising Resperidol as superior to Halperidol, the first generation of neuroleptics. But Janssen had another strategy. Through a partnership established among the APA, psychiatrists and the pharmaceutical companies during the 1980s—a time when drug sales were down and few wanted to enter the field of psychiatry—researchers could make claims both in medical journals and to the press, that the FDA contested (Whitaker, 2010). The results of the trial data for Olanzapine included 20 deaths, 22% suffered a “serious adverse event (higher than in the haloperidol patients) and two-thirds failed to complete the studies” (Whitaker, 2010, p. 301). Side effects included but were not limited to: excessive sleep, obesity, Parkinsonian symptoms, akathisia, dystonia, hypotension, diabetes, seizures, tachycardia, impotence, and white blood disorders. The above results were disregarded by those psychiatrists from medical schools who were backed by the pharmaceutical companies, and who joined in the effort to promote the efficacy of the atypicals (Whitaker, 2010).

If schizophrenia is primarily understood as a biological disease, then psychiatrists may continue to claim legitimacy as physicians treating physical illnesses just as any other medical doctor, and pharmaceutical companies derive the profits from its treatment. So long as they

promote the party line, the APA and NAMI, continue to have their events and programs subsidized by the pharmaceutical industry. If these diseases are irreversible, then those diagnosed need to stay on the drugs and Pharma makes a profit for the duration of their lives. The drugs create chemical imbalances in the brain which both requires long-term use and often, the addition of another drug to address the symptoms caused by the first. Zyprexa, introduced by Eli Lilly in 1996 drew in one billion dollar revenues by 1998 (Whitaker, 2010). Charles Nemeroff, Emory Medical Schools Chair of the Department of Psychiatry received \$2.8 million from drug firms over a seven-year period to promote psychotropic drugs (Whitaker, 2010). These are just two examples from a disturbingly pervasive blurring of the boundaries of medicine and capitalism in the United States. The US spent \$170 billion on mental health in 2008, two times what it spent in 2001, and is projected to spend \$280 billion on mental health by 2015. Federally sponsored programs such as Medicaid and Medicare absorb 60% of the cost of these services (Whitaker, 2010). Whitaker writes,

Such is the story of the psychiatric drug business. The industry has excelled at expanding the market for its drugs, and this generates a great deal of wealth for many. However, this enterprise has depended on the telling of a false story to the American public, and the hiding of results that reveal poor long-term outcomes with this paradigm of care (2010, p. 328).

Countertransference.

Knapp and Lipner suggest that “prevailing biogenetic emphasis has impinged on the countertransference field,” arguing that so long as psychosis is chiefly conceptualized as an irreversible brain disease “history is irrelevant and utterly meaningless,” and the prognosis is without hope (2003, pp. 48). Countertransference may therefore play a role in both the

approaches to and scope of treatment that is available to individuals diagnosed with schizophrenia. Therapists' feelings towards patients' have been found to be directly attributable to agency context and climate (Holmqvist & Fogelstam, 1996). The dearth of adequate training in conducting psychotherapy with psychotic patients is thought to be both a cause and an effect of such resistance to employing meaning-making approaches when working with patients experiencing psychosis (McWilliams, 2011; Karon, 1992).

Unfortunately, there are few empirical studies examining clinician countertransference with regard to particular client populations; and of the studies that have been conducted, many lack clear and consistent definitions of countertransference, draw from small sample sizes, and problematic psychometric instruments (Schwartz et. al., 2007). However, clinicians with a psychoanalytic orientation discuss the increased difficulty in tolerating countertransference when working with clients diagnosed with schizophrenia (McWilliams, 2011; Laufer, 2010; Walsh, 2011; Schwartz et. al, 2007). Nancy McWilliams recalls, "I should not work with a schizophrenic, a supervisor once told me, unless I was prepared to be eaten alive" (2011, pp. 63). She describes the countertransference engendered by the dependence, gratitude and tendency towards fusion of those experiencing psychosis as encompassing the positive and negative valence of maternal feelings towards children during their first eighteen months (2011).

Fromm-Reichmann warned her students and her colleagues, that one must be humble enough to tolerate the injury to their own self-image when unable to understand what is being communicated by the psychotic patient: "when dealing with the psychotic it is not our prestige but the prestige of the patient which is at stake in the treatment" (Reichmann as quoted by Hornstein, 2000, p. 43). She saw the biological stance of incurability as a defense against the psychiatrist's fear of impotence whose job it was to endeavor to

awaken in [the patient] the conviction that he is not suffering from an incurable disease but from one which, in principle, he can be cured...to reduce him to a disease entity was an insult to his humanity and a sign of the doctor's lack of imagination...the physician's desire for certainty and routine couldn't be allowed to take precedence over the patient's needs (Hornstein, 2000, p. 43).

Ferenczi echoed these sentiments in his critique of Freud's dismissal of the psychotic as unanalyzable. In Ferenczi's eyes, it was Freud and other likeminded psychiatrists' countertransference rather than patient resistance that stood in the way of a successful analysis (Hornstein, 2000, p. 44). Difficulty in tolerating countertransference when working with psychotic clients has also been attributed to the clinician's resistance to

facing facts about ourselves, our families, and our society that we do not want to know, or to know again (in the case of repressed feelings and experiences). Families and professionals are settling for treatments that aim at making the patient a lifelong cripple who is not too disturbing (Karon, 1992, pp. 191).

Important to note here are the potential layers of personal, familial and societal resistance to knowing what those who experience psychosis are without the ability to deny. As Castillo has pointed out, investigators that conducted a 1987 WHO-sponsored study found that traumatic or stressful events were likely to have taken place 2-3 weeks prior to the onset of psychosis. Goodman, Rosenberg, Mueser, and Drake (1997) found in a review of 13 studies of seriously mentally ill women that 45–92% had experienced childhood sexual or physical abuse. Friedman and Harrison (1984) found that 60% of a sample of schizophrenic women inpatients had suffered childhood sexual abuse. Honig et al. (1998) found that 83% of a sample of men and women schizophrenics had suffered childhood abuse or emotional neglect, and that 65% related the

initial onset of psychotic symptoms to childhood abuse or other traumatic events. Likewise, in a psychiatric emergency room sample, Briere, Woo, McRae, Foltz, and Sitzman (1997) found that 53% of women who had suffered childhood sexual abuse were positive for non-manic psychotic disorders.

In spite of these findings, psychotic patients are rarely asked by their clinicians about a personal history of abuse or trauma, particularly by biogenetically oriented clinicians (Read and Fraser 1998a; Young, Read, Barker-Collo, and Harrison 2001). Moreover, because of an assumption of genetically based brain disease, treatment for abuse and trauma is rarely provided for schizophrenic patients (Read and Fraser 1998b), (Castillo, 2012, p. 16).

The prevailing biological model as barrier to treatment of psychosis.

With the advent of managed care and Big Pharma, psychiatry has even more of an interest in aligning itself with the biological narrative of schizophrenia. Not only does a genetic antecedent for mental illness fit conveniently with a brain chemistry imbalance model, it allows mainstream psychiatry to participate in the mapping of the human genome lending it more credibility as a proper medical science (Boyle, 2012).

As I have hoped to make clear in this chapter, just as psychosis may arise from a number of variable factors, the biological narrative of the schizophrenia serves numerous social, cultural, economic and psychological interests, and lends itself to a conception of mental illness that is incurable and intrinsic rather than conditional and transient. If schizophrenia is a brain disease, neither the family nor the society are implicated, and it is deemed justifiable to ‘remove’ the symptom-bearer from society to ‘help’ them and to treat them against their will (Boyle, 2012, p. 238). If schizophrenia is a brain disease, then mental health professionals don’t have to make

themselves vulnerable to that intensity of suffering palpable in the meaning-making endeavor, nor do we need confront our own shortcomings in puzzling out such meaning. As it stands, medical schools, departments of social work and psychology, and the majority of internship and field placement settings actively discourage students from addressing patients with psychosis from a meaning-making stance. Even patients of financial means face difficulty accessing meaning-making treatment. If schizophrenia is a brain disease we either have it or we don't. Those of us who don't may fancy ourselves impervious to psychosis no matter the environmental stressors that come our way. A biological narrative of schizophrenia allows us to recast political dissent as mental illness (Metzl, 2009; Applebaum, 2003) and allows us to turn a blind eye to the racism, classism, homophobia and sexual violence that riddles our intimate relationships and our public institutions. If schizophrenia is an incurable brain disease, then managed care's refusal to reimburse for intensive psychosocial treatment programs is justified, and there is little alternative to lifelong maintenance on neuroleptics that for too many, damage the brain and blunt the mind.

Why is it important to offer meaning-making approaches to treatment?

Sadly, the long and robust history of the critique of the biological narrative of schizophrenia does not seem to have made significant headway in decentering it (Boyle, 2012; Poland, 2007). Poland suggests that we create counter advertisements to those of the pharmaceutical companies, draft alternative text books, work for policy reform in access to health care, clinical evaluation criteria, mental health legislation, research funding, develop alternative clinical and scientific frameworks and alternative training programs for clinicians and researchers who are in the fields of cognitive science and neuroscience (2007, p. 148).

Kirkbride's research into multifactorial risk factors points to the possibility that there is

not “one road” to the development of symptoms that are grouped under the DSM diagnosis of schizophrenia (2011). The idea that there may be divergent etiologies suggests the efficacy of making available an array of treatment modalities (such as CBT, peer-led support groups, assertive community treatment, supportive education, open dialogue, psychodynamic approaches, medication) and lends itself to the arguments of the critics of the brain chemistry model and psycho-pharmacologically-driven treatment who ask, if anti-psychotics are the answer, why is it that since the introduction of Thorazine in the 1950’s, the U.S. disability rate due to psychotic illness has increased by four times (Whitaker, 2010; Hornstein, 2009)? Furthermore, why is the medical establishment resistant to meaning-making approaches even as they are presented with the striking success of the Open Dialogue model and the widespread failure of pharmaceutically driven treatment? According to today’s evidence, no one has been able to locate a single biological or environmental determinant for psychosis. Given what we know about the high correlation between psychosis, traumatic experiences and socio-economic stressors, it is incumbent upon mental health practitioners to ensure the option of meaning-making approaches to treatment of psychosis.

From my perspective as a social work student who has been actively discouraged from learning meaning-making approaches to working with individuals diagnosed with schizophrenia, raising awareness about the viability and utility of such options as Open Dialogue, Hearing Voices Network and the Maastricht Approach, and the inter-subjective school of psychoanalysis may help to increase the options for those who wish to seek treatment that departs from the strictly medical model. In the next chapter, I will look at the ways in which those diagnosed with schizophrenia conceptualize their own experiences, and the psychosocial supports that have developed from a grassroots rather than professional context, with particular attention to the

Hearing Voices Network. Chapter Five and Six will examine the theoretical base, technique and outcomes of the interpersonal and intersubjective schools of psychoanalytic psychotherapy and Open Dialogue.

CHAPTER 4

The C/S/X Movement and the Hearing Voices Network

This chapter examines perspectives on coping with hearing voices and other unusual or extreme experiences from the perspectives of those active in the consumer/client/survivor/ex-patient (c/s/x) movement both in the United States and abroad. It begins with an exploration of c/s/x narrative themes and goes on to discuss the role of subjective experience in the influential research of Dutch psychiatrist Marius Romme and the related development of the Hearing Voices Network.

C/S/X Literature

C/s/x literature on the subject of madness and how it is and/or should be treated has a long and rich history. Since the 1400s, six hundred first-person accounts of madness have been published in English (Adame & Hornstein, 2006). Some better known contemporary works include Greenberg's *I Never Promised You a Rose Garden*, Saks' *The Center Cannot Hold*, and Redfields *An Unquiet Mind*. Chamberlain's *On Our Own: Patient Controlled Alternatives to the Mental Health System* (1978), represents a growing body of literature that not only offers a firsthand account of the experience of madness; but offers a critique of the prevailing psychiatric system as well as a way forward for those who seek alternative pathways toward recovery. Rufus May (2000), Jacqui Dillon (2012), Egan Bidois (2012), Patte Randal (2008) are but a few of the

growing numbers of mental health professionals who write and speak openly of their own experiences with psychosis and how these experiences have enabled them to straddle the ‘doer and done-to’ (Benjamin, 2004) divide. Notably, Dillon, May, Bidois and Randal hail from the UK, Australia and New Zealand respectively, where the medical model of psychosis is significantly less entrenched.

The dissension between the *c/s/x* literature and the “professional literature” can be understood as a divide between the privileging of subjective and objective experience (Randal et al., 2008; Estroff, 2004). These positions can be difficult to reconcile, especially in a climate as polarized as the United States. Estroff has characterized this impasse as an ‘us versus them’ model in which the *c/s/x* community contends that in order to be an expert on psychosis, one must have firsthand experience with psychosis themselves; and the psychiatric community claims that those who have firsthand experience of psychosis are discredited by the fact that they are “lacking in insight” (Estroff, 2004). Thornhill, Clare and May point to a dearth of psychiatric literature

focusing on subjective accounts of psychosis and recovery. This is partly due to the swing in psychiatry and psychology in the twentieth century towards positivism and the use of positivist scientific methods, such as statistical analysis of numerical data. It is increasingly recognized in the twenty-first century that the pendulum has been allowed to swing too far in this direction and that work is needed to redress the balance (Faulkner & Thomas 2002; Roberts 2000). The use of methods which allow for an understanding of the lived experience of individuals, through the study of language and meaning in texts and dialogues, is required in order to

influence and deepen our knowledge base (2004, p. 182).

One of the many glaring examples of the consequences of absence of subjective experience in psychiatric literature is the misperception of negative symptoms as a lack of feeling (Longden, 2012; Karon, 2003). Longden is a voice hearer diagnosed with Schizophrenia and the research coordinator for Intervoice, the international network for training, education and research into hearing voices. She writes

The paradox is that we are not devoid of emotions, we are overwhelmed and crushed by them... a 'paucity of affect' relates only to the articulation of one's feelings, not the feelings themselves. This incongruity is driven by the misguided assumption that objective assessments of emotion, as made by psychiatric professionals, accurately correspond to the subjective life of the individual under scrutiny... a diverse and meaningful emotional life has traditionally been denied individuals designated as 'schizophrenic'; emotion is either dismissed as disturbed and disorganized, or else presumed to be entirely absent. Yet the notion that emotionality communicates one's humanity reinforces the cultural conclusion that those with psychosis are less than fully human (2012, p.184).

Adame and Hornstein have pointed out a crucial difference between narratives of physical illness and narratives of 'mental illness.' In most cases, physical illness assumes a separation of harm to the body and harm to the mind. A patient would be more apt to say, "I have cancer" than "I am cancer" (Adame & Hornstein, 2006, p. 137). When considering iatrogenic effects of treatment, psychiatry's emphasis on diagnosis as identity may be one of the reasons why the narrative act has such a central and powerful role in c/s/x-led recovery movements.

In a study of mental health recovery narratives, Thornhill, Clare and May observed three primary categories of escape, enlightenment and endurance (2004). While psychiatric literature does not address or acknowledge the iatrogenic effects of treatment so prevalent in the c/s/x literature, c/s/x views the suffering of the diagnosis of Schizophrenia as inseparable from its treatment. Iatrogenic-related issues raised by c/s/x activists include the traumatic effects of being involuntarily hospitalized, loss of dignity, drug induced sedation and confusion, being told their explanation of their illness is wrong and problematic, and loss of agency in the healing process (Estroff, 2004). Longden writes,

...the crushing impact of neuroleptics may mean that many 'negative symptoms' are better explained as side effects of anti-psychotic medication. It may be helpful in the short-term of emotional crisis to soothe the person through sedation, but in the long-term I believe it diminishes recovery prospects, simply because coping with emotion is not learned (2012, p.186).

It has been argued that psychiatry would do well if it were to be informed by the subjective experience of those who experience psychosis and recovery from it, and have pointed out a marked disjuncture between medical and c/s/x definitions of recovery (Salem, 2001; Thornhill, et al., 2004; Adame & Hornstein; 2006). The psychiatric community conceives of recovery as the absence of symptoms or ceasing to meet diagnostic criteria, in contrast to the c/s/x community who emphasizes the renewed ability to pursue life goals (Salem, 2011; Thornhill et al., 2004). For example, Schizophrenia Anonymous (SA), founded in 1985 by Joanne Verbanic, a woman diagnosed with Schizophrenia in Detroit, MI, outlines the following phases of recovery: 1) mourning and grief, 2) awareness and recognition, 3) redefinition and transformation, and 4) enhanced well-being and quality of life. In SA, arriving at stage four does not mark the end of

the recovery process which is understood to move back and forth between the phases as life presents new challenges (Salem, 2011). Other values of the c/s/x recovery movement in the United States, United Kingdom, Australia and New Zealand include: being an agent in the recovery process rather than “passively complying with professional treatment” and “developing a voice and reclaiming ownership of one’s experience” (Thornhill et al., 2004, p. 183). Narrative or meaning-making opportunities in a communal setting are understood to be a key component of developing a voice and reclaiming ownership of the recovery process in that it holds out the possibility of hope (Salem, 2011; Thornill et al., 2004). The utility of self-help groups in the recovery process is further articulated by Salem,

individuals’ stories of recovery are influenced by the availability of positive community narratives within the settings where they seek to find meaning in their experiences. The adoption of a narrative is facilitated by the presence of structures and processes that are consistent with its underlying message. This is particularly likely to be true when the community narrative of the setting is at odds with the dominant cultural narrative or with the community narratives of other important meaning-making contexts in individuals’ lives. If most of the meaning-making resources in an individual’s life are communicating a pessimistic message about recovery, it will take more than a hopeful story to counter that message. Settings that provide structural opportunities and support for living that operationalize a hopeful story are more likely to act as an effective antidote (2011, p. 122-3).

C/s/x support groups such as SA, Intervoice and the Hearing Voices Network (HVN) exist to provide a sense of mutual support and hope to fellow members by: offering the opportunity to share experience in a non-stigmatizing setting; providing role models who have experienced

recovery; and creating opportunities for participants to play meaningful roles in the group and the larger recovery movement. None of these experiences are integrated into the current mental health system (Salem, 2011).

It's been suggested that SA's capacity to counter the dominant discourse of Schizophrenia has been compromised by its structural reliance on mental health professionals who do not identify as voice hearer's themselves. As such, SA has adopted and promoted the view that Schizophrenia is a life-long biological illness (Salem, 2011). The Hearing Voices Network, on the other hand, encourages participants to use the narrative process and the group to make connections between their voices, visions and unusual beliefs and past or present life stressors and traumatic experiences (Romme, 2009; Romme, 2012; Dillon, 2013). In Dillon's words, "Instead of asking what's wrong with you, psychiatrists should ask, what's happened to you" (Hornstein, 2009, p. 166).

The Maastricht Approach

Living with Voices: 50 Stories of Recovery represents a bridging of the gap between professional and c/s/x literature. Edited by mental health professionals, two of whom openly identify as voice hearers themselves, the volume offers guidance regarding the role of clinicians in the recovery process and fifty recovery narratives written by voice hearers themselves (Romme et al, 2009). Dutch psychiatrist Marius Romme's, a co-editor who does not identify as a voice-hearer, began his inquiry into the phenomenon of hearing voices when his patient Patsy Hage demanded that "her voice hearing experiences be taken seriously" (Corstens et al, 2008, p. 320). Romme, who until then had approached Patsy's voice hearing experiences as symptoms of an underlying illness, wondered if it would be of any benefit to his patient to share her

experiences with others who also heard voices. After an initial small group meeting yielded positive results, Romme and Hage went on a nationally televised talk show in hopes of finding more voice hearers and organizing a World Conference on Voice Hearing. Within several days, 450 voice hearers had called in and were sent a detailed questionnaire developed by Romme, Hage and Romme's partner, Sandra Escher, a science journalist. Those who reported they heard voices on a regular basis and coped well with them were interviewed in more depth and invited to speak at the World Conference. Of the 450 voice-hearers interviewed one third reported having had no connection with the mental health system. Upon reviewing the literature, Romme discovered studies that revealed a 10-15% prevalence of hallucinations in the general population (Tien, 1991; Posey & Losch, 1983; Sidgwick, 1894) indicating "hallucinators were no more likely than nonhallucinators to show evidence of psychiatric difficulties... suggesting that voice hearing is a common human experience that cannot, in and of itself, be considered a symptom of mental illness" (Hornstein, 2009, p. 33).

Romme, Hage and Escher conducted intensive studies of the two groups of voice hearers, those who were in the mental health system and those who were not. They found that those in the mental health system were afraid of their voices, didn't know how to cope with them, were likely to be secretive about their voices, used distraction techniques such as loud music, sleeping and substance abuse, and were diagnosed as "psychotic"; whereas those outside of the system were more able to "set limits with their voices, listen selectively to them, and talk with others about their unusual experiences" (Hornstein, 2009, p. 34). Romme and Escher's methodology is distinct from traditional psychiatric research into psychosis in three important areas: 1) the experience of hearing voices was used as the independent variable rather than diagnostic categories; 2) the subjective experiences of voice hearers was privileged over theoretical

formulations; and 3) voice hearers both within and outside of the mental health system were interviewed (Romme & Escher, 2010). Their research, the first of its kind to consider voice hearing as anything other than a psychiatric symptom, led Romme and his colleagues to the conclusion that hearing voices wasn't the problem, the problem was one of how to cope with hearing voices.

The voice hearers Romme interviewed shared that once a psychiatrist learned of voice hearing experiences, they did not inquire into the nature of these experiences and instead prescribed medication they believed would eliminate them. As a psychiatrist himself, Romme also had been trained to refrain from "colluding with the patient's delusional system" (Hornstein, 2009, p. 33). With research data gathered for more than fifteen years, Romme and Escher have solid empirical evidence that 80 to 90 percent of voice hearers attribute their voices to traumatic experiences (Hornstein, 2009). A 2005 survey of 17,337 adults confirms Romme and Escher's findings, indicating that those with extreme early trauma histories were five times more likely to have hallucinations later in life (Whitfield et al, 2005). This data directly contradicts the prevailing psychiatric discourse

that hallucinations are meaningless neural activity unrelated to a person's life experiences. More broadly, their research demonstrates that it isn't the trauma itself that makes someone a psychiatric patient; it's the nature of the trauma, when it occurs, how long it lasts, whether it's denied by others, and whether the person gets help... When the reality of the trauma is acknowledged and symptoms are seen as its consequence, a person doesn't have to mistrust his own perceptions, thoughts, memories, and feelings (Hornstein, 2009, p. 40-1).

Romme and Escher have noted a cycle leading to the onset of voice hearing that begins with

an upbringing of emotional neglect and denial of emotions, is followed by or includes trauma which then gives rise to overwhelming emotions. The individual then resorts to dissociation/repression of these emotions. Emotions are provoked by the renewed onset of stressors, coping fails, and the commenced or resumed voices (Corstens et al, 2008).

The Maastricht approach has been developed in close connection with the subjective experience of voice hearers and a voice dialogue technique that offers a non-pathologizing, non-judgmental model of voices as sub-personalities that can be communicated with productively (Stone & Stone, 1989). Unlike traditional psychiatry, eradication of voices is not the aim. Voices are seen as “meaningful human phenomenon” originating in the history of the individual who was overwhelmed by emotions in threatening circumstances” (Corstens, 2008, p. 331). The treatment proceeds in three phases (startling, organization and stabilization), the first of which is geared toward anxiety management; the second of which is geared toward assisting the voice-hearer with living with their voices; and the third of which addresses how to confront the problems of living that are associated with their voices (Romme & Escher, 2010). Treatment includes a semi-structured interview to understand who and what the voices represent thereby breaking the code; and encouraging communication with voices, assertiveness training, acceptance of past trauma and working through associated feelings of grief, guilt, shame, fear etc. (Corstens et al, 2008; Romme & Escher, 2010). The data gathered from the initial semi-structured interview is compiled into a report that is read back to the voice hearer to confirm accuracy and to stimulate dialogue about the voices. The construct is culled from the report with particular attention to: the voices’ identities, their characteristics and content, history, triggers and impact, childhood and adolescence. There may be more than one equally valid construct and

they should be collaboratively arrived at with the voice-hearer once they have reached the stabilization phase (Romme & Escher, 2010).

In a study of 50 recovered voice-hearers, 44 were prescribed neuroleptic medication. Of these 30 reported that medication was not unhelpful and discontinued their use of it; and 14 participants said medication was helpful in part but not as the sole intervention. Notably, “medication alone never helped people to recover” (Romme & Escher, 2009, p. 97). From these interviews Romme and Escher distilled the following nine themes that were pivotal in the recovery process:

- 1) meeting someone who takes an interest in the voice hearer as a person; 2) offering hope, by showing a way out and normalizing the experience; 3) meeting people who accept the voices as real; being accepted as a voice hearer by others, but also by oneself;
- 4) becoming actively interested in the hearing voices experience; 5) coming to understand the logic of your voices as having to do with your personal experiences 6) choosing life over the voices 7) transforming the power dynamic between the self and the voices; 8) changing the relationship with your voices, seeing the voices as signals; and 9) recognizing one’s own emotions and accepting them (Romme, 2012a; Romme & Escher, 2009).

Hearing Voices Movement

The Hearing Voices Network views itself as a post-psychiatric organization that privileges holistic solutions over reductionist illness models and positions itself outside statutory services in recognition of its view that voices are more appropriately understood as a human variation, like sexuality, rather than as a symptom of a mental disease (Dillon & Longden, 2012,

p. 130-131). The Network grew out of the first World Conference on Voice Hearing organized by Romme and Escher in 1987. Held in Utrecht, it was attended by 250 voice hearers and 50 family members, nurses and mental health professionals (Hornstein, 2009). Since this historic event, support groups for voice hearers began to meet regularly under the aegis of the Hearing Voices Network. There are now over 180 groups in England alone, and other Hearing Voices Networks have sprung up in 21 additional countries including the United Kingdom, United States, South Africa, Palestine, Greece, Denmark, Japan, Malaysia, Uganda and Australia. The international network of Hearing Voices groups is coordinated by Intervoice: The International Network for Training, Education and Research into Hearing Voices (Dillon & Longden, 2012). Groups operate in community-based settings as well as inpatient units and prisons and some are particularly for women, people of color, children or other demographic groups. Most groups are user-led, some are co-facilitated by mental health professionals and those who identify as voice-hearers, and a few are solely facilitated by mental health professionals with the intention of increasing the capacity of the group to be user-led (HVN, 2013). More recently, the Paranoia Network has sprung up as inspired by HVN to support individuals living with unusual beliefs (Dillon & Longden, 2012).

The Hearing Voices Network (HVN) and Movement is greatly influenced by Romme and Escher's work, aiming to:

- 1) to raise awareness of voice hearing, visions, tactile sensations and other sensory experiences;
- 2) to give men, women and children who have these experiences an opportunity to talk freely about this together; and
- 3) to support anyone with these experiences seeking to understand, learn and grow from them in their own way (HVN, 2009).

To realize these aims HVN: promotes and provides assistance to support groups; offers training for health workers and the public; staffs a warm line providing information and assistance to those who experience visions, tactile sensations and voice hearing; facilitates forums in which men, women and children who have such experiences can share openly about them; and publishes four newsletters per year (HVN, 2013).

Through these structures, participants seek to normalize “unusual experiences” such as voice hearing, visions and unusual beliefs and to offer hope that recovery is possible. They assist voice-hearers and others in reclaiming an active role in the recovery process and challenging the passivity of the medical model. Network groups support voice-hearers and others in exploring the meaning of their voice hearing and in making the connection between trauma and distressing unusual experiences with attention to both the personal and political, allowing for a social critique including the trauma of racism, classism, xenophobia, colonialism, homophobia, genocide etc. (May, 2012). They reduce the stigma and social isolation experienced by voice hearers and offer participants the opportunity to be of service to others. HVN groups assist members in reducing the fear, anxiety and avoidance response, identifying patterns, strategizing how best to set boundaries with voices, and in so doing, privileging the experience of other voice hearers over professional expertise (Dillon and Longden, 2012).

Groups are organized on the basis of shared experiences rather than on the basis of shared diagnostic categories. This sense of shared experience, strength and hope reinforces participants’ agency and inspires courage and strength to face the challenges of recovery and the difficulties of self-knowledge or facing traumatic experiences of the past (Dillon & Longden, 2012). A premise of the movement is that the act of creating space for the individual to tell their stories on

their own terms with their own paradigms and values, in the context of a receptive and accepting community is an act of healing itself.

The point isn't to have an 'anything goes attitude' but to create spaces and methods of communication that can hold more than one belief system simultaneously so that there is not a power struggle to impose one system of belief on another as the only credible or legitimate truth (Thornhill et al., 2004).

Construct vs. diagnostic category.

The Hearing Voices Network has adopted Romme's notion of the "construct" to assist group participants in gaining insight into the meaning of their voices with the intent of finding "ways of dealing with that belief and finding some sense of power, control and hope within it" (HVN, 2013). The construct includes social contexts and relationships, is collaboratively arrived at, is malleable and participatory, non-stigmatizing, holds no medical or social consequences, promotes agency and creates personal meaning. It promotes an active role in the healing process and the agency of the voice hearer, and answers voice-hearer's need for an explanation for their voices (Johnstone, 2012). Unlike diagnosis, if a voice-hearer does not find the construct resonant or useful, it is discarded. While diagnoses rely on western psychological frameworks, constructs are compatible with mystical, religious, metaphysical, paranormal, psychological and medical frameworks, and accommodate the spiritual emergency paradigm (Grof & Grof, 1990) that is consistent with many non-western cultural explanations of hearing voices (Bidois, 2012; Randal et al., 2008). The Network does not conflate voice hearing or other unusual experiences with illness, promoting a liberatory rather than a curative model of emotional, mental and spiritual health. While they may play a helpful role for some, HVN does not view mental health

professionals as necessary to the process of formulating the construct or supporting the voice-hearer in the recovery process (Johnstone, 2012).

Unusual beliefs.

Practitioners and participants have found that with the reduction and social isolation provided by HVN groups, unusual beliefs become less important when members have social connection. Hearing others' stories and needing to respect them helps members to be more flexible about their own unusual beliefs (May, 2012).

As has been mentioned, the Hearing Voices Network has met with such success as it has inspired those with unusual or extreme beliefs to found the Paranoia Network. Consistent with HVN's stance with regard to voices, the Paranoia Network suggests that it's not important whether or not someone holds an unusual belief, but rather how much anxiety and distress the belief causes them and the extent to which it interferes with their ability to live life in accordance with their values. Rather than an automatic dismissal of paranoia, these beliefs are normalized as: arising in a societal context of surveillance and socioeconomic oppression; having been inherited from past generations in the case of secondary survivors of trauma; or having earlier personal experiences of having been monitored or controlled. In this case as well, the iatrogenic effects of psychiatric treatment are often relevant, and validated (May, 2012). Hornstein, who has sat in on groups facilitated by the founders of the Paranoia Network reflects,

being in an accepting, safe context is a crucial first step in easing suspicions. People who are very mistrustful don't have many opportunities to check out their ideas with anyone else. A support group composed of others who are suspicious has the paradoxical effect of easing each person's anxieties and fears...part of the reason that mental health professionals don't realize this is that their assumptions about 'impaired cognitive

processes' blind them to the variability that actually exists among people with paranoid diagnoses... If they take a biological view of distress, it won't occur to them to think that these same patients might behave very differently with their peers (2009, p. 139).

Richard Bentall, Chair of Clinical Psychology at the University of Bangor, UK argues that mainstream psychiatry's 'poverty of ideas' regarding the treatment of individuals with paranoia are reflective of the very rigidity of the cognitive process that they are purporting to treat. Acknowledging the high proportion of individuals diagnosed with paranoia that are socioeconomically oppressed, he calls on mental health professionals to treat paranoid individuals as rational beings capable of developing their capacity to cope with their difficulties—be they personal or societal (Hornstein, 2009).

Activism in the healing process.

As has already been mentioned, unusual experiences be they voice-hearing, visions, tactile sensations or extreme beliefs, are highly correlated with individuals with extensive trauma histories (Romme, 2009; Romme, 2012; Dillon, 2013; Whitfield, 2004). Romme would go so far as to claim a causal relationship between traumatic experience and the propensity to have unusual or extreme experiences (Romme, 2009; 2012). The Hearing Voices Network offers a recovery model similar to that of Judith Herman's three stages of: 1) safety and stabilization; 2) mourning and remembrance; and 3) reconnection (Herman, 1992). The Network offers participants a sense of safety and stabilization through an accepting community, normalizing and validation of participant experience and offering participants concrete techniques to assist them in coping with their unusual experiences. Groups encourage participants to address past trauma and to process associated emotions of grief, guilt, anger, helplessness and shame. And perhaps, most importantly, HVN groups provide participants the opportunity to reconnect with others

through offering hope to new members, facilitation of meetings and raising awareness of mental health professionals and the public at large via involvement in the broader c/s/x movement.

For many voice hearers and psychiatric survivors, active participation and social action supports and enhances the recovery process; having a shared survivor mission (Herman, 1992), and becoming part of a collective voice creating change in the world, both inside and out, is healing, empowering and liberating (Dillon, 2013).

Transparency, non-hierarchical decision-making and the role of professionals.

The role of asymmetrical power relations in trauma and in giving rise to mental distress suggests that a power analysis should be taken into account in the healing process. The c/s/x movement is duly informed by a power analysis, and as such the structure of the Hearing Voices Network, has been shaped to attend to these dynamics. In the United States, the biological discourse of mental illness is so prevalent that c/s/x movement is more apt to exclude health professionals. This has been less true in the UK where the medical model is less entrenched, and where mental health professionals have played a more supportive role in the growth of the Hearing Voices Movement (Hornstein, 2009). In 2000, the British Psychological Society incorporated HVN's assumptions into its revised guidelines for conceptualization and treatment of psychosis, and in 2003, the UK's National Health Service paid for its mental health professionals to be trained by voice-hearers, and refashioned many of its services in alignment with HVN's principles (Hornstein, 2009). As noted, many groups are 100% user led, some are co-facilitated by both a mental health professor who does not have firsthand experience of hearing voices and a voice-hearer, and some groups are entirely led by those with professional experience but no firsthand experience. Those solely facilitated by mental health professionals with no firsthand experience are strongly encouraged to involve those with lived experience of

voice hearing in the running of the group (HVN, 2013). The UK's Hearing Voices Network is an independent charity

that stands as a distinct and very different organisation to that of the Mental Health Services in terms of culture, ethos, philosophy and values (HVN, 2013).

The Network draws a distinction between self-help groups and treatment groups, maintaining that HVN is a network of self-help groups founded on the principles of acceptance and self-determination rather than psychiatry's illness and treatment group model. Groups may enjoy one of two levels of association with the Network, affiliated membership or full group membership. An affiliated group must be working to meet full group criteria so that it:

accepts people as they are; makes no assumption of illness; is a social group not a therapy group; is a community to which people belong; upholds equality between everyone in the group including the facilitator; makes all the decisions collectively; decides on the limits to confidentiality not the facilitator; works out problems collectively; holds responsibility not the facilitator; members join for as long as it suits them; is open to people not using mental health services; is open to people from other geographical areas; does not meet within a clinical setting; facilitator is not under pressure to report back to anyone outside the group; and aims to become a user-run group if it isn't already (HVN, 2013).

The criteria emphasizes member ownership of the group, nonhierarchical transparent decision-making, individual choice (to attend as much or as little as they wish), and the absence of an allegiance to or reliance on the psychiatric system. The Network's website offers HVN participants suggestions about how to fundraise to support the modest budgets of most groups. Intervoice, International Network for Training, Education and Research into Hearing Voices was cofounded by Patsy Hague and Marius Romme. The board includes mental health professionals with and without firsthand experience of hearing voices, and the advisory board is

comprised of four voice-hearers, several of whom have been diagnosed with schizophrenia (Intervoice, 2013). The World Hearing Voices Congress, whose representatives and members of the international networks meet annually, is a clearing house for innovative practice, translation of materials; supports the development of hearing voices groups in new countries; and builds a sense of community across borders (Dillon, 2013).

Dillon, a member of the campaign coordinating committee for CASL – the Campaign to Abolish the Schizophrenia Label, is not alone in welcoming mental health professionals into the fold of this liberatory project:

This is also true for many mental health workers, who have become increasingly disillusioned with an inadequate biomedical model, disturbed by the collusion demanded of staff in a mental health system driven by fear, control and bureaucracy. For them, becoming part of the Hearing Voices Movement also enables a recovery of meaning, purpose and optimism, a renewal of important values, a rediscovering of a sense of self. For all of us, the possibility of reconnecting to ourselves and each other as unique and equal human beings, is life affirming... One of the fundamental strengths of the Hearing Voices Movement, which has led to its extraordinary success, is that it is based on mutually respectful relationships – authentic partnerships between experts by experience and experts by profession, working together to bring about the emancipation of voice hearers (Dillon, 2013).

Hearing Voices USA.

While a small number of hearing voices groups have been meeting in Wisconsin, California and Massachusetts for the past five years, Hearing Voices Network USA was founded in 2010 and

represents individuals who have voices, visions or unusual beliefs as well as professionals and allies who are invested in

change the assumptions made about these phenomenon and create supports, learning and healing opportunities for people across the country (Hearing Voices Network-USA, 2013).

The USA arm of the Network supports the development of new groups, promotes the Hearing Voices approach, and serves as a vehicle to connect likeminded groups (Hearing Voices Network-USA, 2013). The Network offers facilitator training throughout the country and its website maintains a directory of active groups. Twenty-eight groups that meet full membership criteria are currently listed on the website in Arizona, Idaho, Massachusetts, Michigan, New Jersey, New York, Oregon, Pennsylvania, Vermont, and Wisconsin.

Efficacy and evaluation.

An important question is, how do we quantify the efficacy of HVN groups in accordance with today's standards of evidenced based practice? Longden and Dillon have discussed the difficulty of capturing the outcomes of this model as people derive benefit from the online presence, just knowing there is a meeting, having a friend who goes, and point out that not going weekly doesn't demonstrate anything in particular... (2012). At present 21 countries in Africa, Asia, Australia, Europe, North and South America now have their own networks and there is no end of first-person testimony as to their efficacy (Romme, 2009; Hornstein, 2009; Dillon, 2012; Johnstone, 2012). Based on the perceived success of HVN, the National Paranoia Network was founded to develop an analogous community to support those who hold unusual beliefs (May, 2012). In her research sponsored by a grant from the Mental Health Foundation, psychiatrist Tamasin Knight, a mental health professional who was hospitalized for delusional beliefs, found

that self-help groups such as HVN were found to be valuable resources for coping utilized by study participants (Knight, 2009). Unlike the medical model that has been heavily promoted by the financial backing of the pharmaceutical industry, the Hearing Voices groups are a grassroots effort, with the subjective experiences of voice hearers guiding the way.

With the principles of the *c/s/x* movement foremost in mind, the following two chapters will explore the theoretical underpinnings, techniques and outcomes of using interpersonal and intersubjective psychoanalytic theory and open dialogue to address psychosis.

CHAPTER 5

Interpersonal, Intersubjective and Phenomenological Theory

This chapter will examine several trends in psychoanalytic and psychodynamic approaches to the treatment of schizophrenia with a focus on the interpersonal and intersubjective schools. I will begin with Harry Stack Sullivan and Frieda Fromm-Reichmann, both associated with the American interpersonal school of psychoanalysis, and their more contemporary “followers” such as Anne-Louise Silver and Bertram Karon, clinicians who have continued to advocate for the efficacy of psychodynamic treatment of psychosis during the current hegemony of the biological model. I will then turn to the intersubjective school of psychoanalysis and the clinicians such as Paul Lysaker and George Stranghellini who draw both from this tradition and phenomenological psychiatry to inform their therapeutic practice with patients who have been diagnosed with schizophrenia. While it goes without saying that psychoanalytic and psycho-dynamically informed treatment is at its heart, a meaning-making endeavor, it is also an endeavor bound up in the therapeutic aspects of being in relationship. The ways in which these two dimensions of psychotherapy are deployed in the treatment of psychosis is a central concern of this chapter.

Much of the literature reviewed in Chapter 6 is in stark contrast to the writings of the c/s/x movement in terms of accepting the diagnostic category of schizophrenia, and referring to the experiences of hearing voices, seeing visions and holding unusual beliefs as hallucinations

and delusions. In other words, while the prior chapter described a way of conceptualizing mental distress without pathologizing the one who experiences such distress, or asserting one truth at the expense of others, this is less resolutely the case for the way psychosis is framed by the practitioners of psychoanalytic, intersubjective and phenomenological psychiatry whose work is explored in this chapter. My use of this pathologizing terminology to outline the following theoretical and technical approaches is not without hesitation. I hope the reader will keep in mind the critiques of this pathologizing gaze, so cogently offered by the c/s/x movement, while exploring the contributions of the following clinicians and theorists.

The Interpersonal School of Psychoanalysis

Harry Stack Sullivan.

From 1923 to 1930 Harry Stack Sullivan worked as the Assistant Physician and then Director of Clinical Research at Sheppard-Pratt Hospital in Towson, Maryland (Perry, 1962; Perry, 1982). He was the only child of a poor family of Irish catholic immigrants in a Protestant town during the Great Depression. Sullivan experienced a psychotic break early in his life and struggled a great deal with interpersonal difficulties throughout his life (Perry, 1962; Perry, 1982). His many contributions include: successful treatment of young men diagnosed with schizophrenia; promoting the relational approach to psychotherapy in the United States; and his non-pathologizing and sociological rather than intrapsychic perspective.

Sullivan's conceptualization of interpersonal theory arose as a critique of the prevailing models of Kraepelin's descriptive or biological psychiatry on the one hand and the emphasis on intrapsychic rather than interpsychic processes in Freud's conception of psychoanalytic theory, on the other. Where Freud, Jung and Kraepelin were concerned with individual

psychopathology, Sullivan offered a theory of the human personality in relation to his social context (Evans, 1996).

Sullivan's critique of descriptive psychiatry.

According to Sullivan, descriptive (Kraepelinian) psychiatry resulted in: objectification; iatrogenic ostracization due to labeling; the failure to take into account social and cultural forces particularly the pressure to conform and the ways in which people's anxiety about those who don't conform 'could turn a troubled person into a social outcast' (Evans, 1996, p. 56); the disastrous neglect of countertransference (e.g. the therapist is triggered by patient and diagnosis them as schizophrenic, treats them as if they are and patient responds in kind); and the privileging of an individual's symptoms and pathology

as objective indicators of disease, instead of examining the experience of the patient to ascertain what meaning it had to the patient and what particular interpersonal experiences caused and maintained the symptoms... Sullivan concluded that Kraepelin's over-reliance on traditional medical diagnosis could readily obscure the underlying complexity of how specific psychological processes arising from an idiosyncratic developmental history lead to the individual's difficulties (Evans, 1996, p. 136).

Sullivan's critique of classical psychoanalysis.

Everything that has been found in the mind has been put there by interpersonal relations, excepting only the capabilities to receive and elaborate the relevant experiences. This statement is intended to be the antithesis to any doctrine of human instincts

--(Sullivan, 1950, p. 302).

Sullivan differed from Freud in that he did not believe in the libido or the drives so much as in the profoundly impactful interplay of the child's attempts to get his or her needs met,

parents' and society's response to these needs and the corresponding anxiety. In Sullivan's understanding, if a child's needs aren't met by parents and society, they will be satisfied by the child in a covert fashion which can grow to be split off (dissociation), which Sullivan believed was only in response to the untenable situation in which "the bad mother cannot be avoided nor can the good mother be called" (Evans, 1996, p. 89). Sullivan characterized this splitting off as a 'not me' experience, the cumulative effect of enduring many 'not me' experiences during childhood contributed to what is described by psychiatry as schizophrenia.

Dissatisfied by the intra-psycho system of defense mechanisms elaborated by Freud, Sullivan developed a contrasting inter-psycho system of security operations developing from and arising in interpersonal situations. Sullivan believed that anxiety and loneliness were at the heart of all mental disorders and that loneliness had to do with security operations (dissociation, sublimation, selective inattention, substitutive processes) put into place to guard against anxiety (Evans, 1996). Initially he referred to these operations as dynamisms, but changed his language to inadequate or inappropriate interpersonal relations to be consistent with his critique of the experience-far jargon that typified psychiatry and psychoanalysis (Evans, 1996).

Sullivan also questioned the universality of the Oedipus and Electra complexes. He believed that tenderness between children and parents need not be confused with lust; and that patterns of socialization were more predictive of child development than were arrest at various psychosexual stages as suggested by Freud. Sullivan emphasized the impact of the juvenile stage on personality development, highlighting the socializing force of school that offered the child the opportunity for corrective experiences where they could compare their parents to other adults (teachers and other students' parents) and also to their peers. He was equally mindful of the debilitating effects of social ostracism and stereotyping and was ahead of his time in calling

attention to the deleterious effects of racism and anti-Semitism on the psyches of both the targets and the perpetrators (Evans, 1996). In place of the superego, Sullivan developed the notion of supervisory patterns, imaginary censors of the eyes of their peers that are internalized during the juvenile era. In contrast to the psychoanalysts practicing during his era, Sullivan believed that much personality growth occurred after the age of ten, as a result of negotiating interpersonal relationships with peers in youth and adolescence.

While Freud identified lust or libido as a primary instinct, Sullivan asserted the primacy of loneliness, the “frustrated need for intimacy” (Evans, 1996, p.117), which he believed originated in the pre-adolescent stage. He identified difficulty in integrating lust, intimacy (avoidance of loneliness) and security (avoidance of anxiety) as the three primary forces at play in interpersonal situations (Evans, 1996). Societal prohibitions around sexuality were understood by Sullivan to lead to problems in integrating lust (such as the bad me associated with masturbation). He claimed that when parents confused the child’s desire for intimacy with the opposite sex for lust, prohibited the relationship and ridiculed the child for such feelings, this could instigate the guarding operations that might lead to paranoia (Evans, 1996).

Two further departures of Sullivan’s interpersonal theory from classical Freudian theory are important to note. Sullivan challenged the viability of the blank slate, and instead promoted the approach of participant observation that he in part substantiated by the Heisenberg principle, that there is “no purely objective data in psychiatry” because the personality of the psychiatrist is implicated in the process of observation (Sullivan, 1954). Sullivan taught that how an individual shares his life with the therapists is mediated by his interaction with the therapist and related social and cultural pressures, making the internal life of the individual ultimately unknowable (Evans, 1996). Freud viewed countertransference as an obstacle to objectivity and believed that it

was possible for the analyst to be analyzed to the extent that they would no longer be influenced by it. Sullivan was strongly influenced by the lectures of Hungarian psychoanalyst Sándor Ferenczi when he visited the US in the late 1920s. Ferenczi viewed countertransference providing valuable information about the subjective experience of the client (Sinason and Silver, 2008). In turn, Ferenczi and Sullivan had a strong impact on the psychotherapeutic practices of Frieda Fromm-Reichmann and Bertram Karon. Their work will be more fully discussed later in this chapter.

Conceptualization of psychosis through the lens of Sullivan's interpersonal theory.

Sullivan redefined psychiatry as the science of interpersonal living. His one-genus hypothesis described schizophrenia as a human process, promoting the stance that humans are more alike than different, and that psychotherapy ought to be a project of working together to understand our common humanity from an empathetic, experience-near rather than objectifying and pathologizing perspective (Evans, 1996).

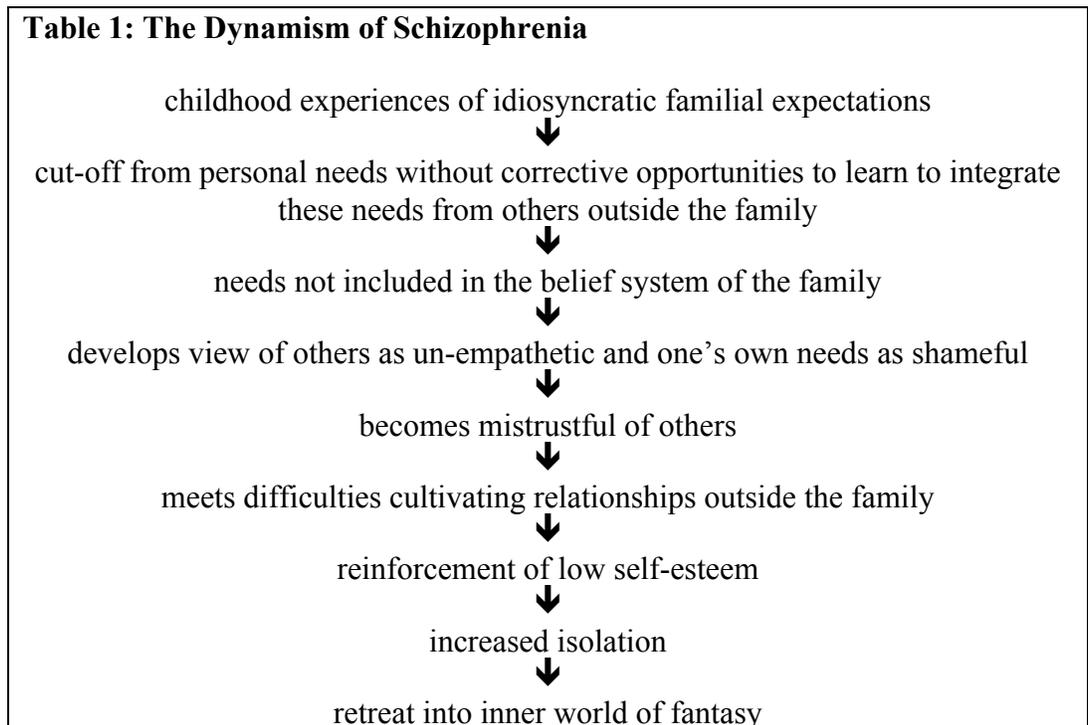
That said, Sullivan distinguished between two kinds of schizophrenia: 1) dementia praecox defined as an organic degenerative disorder, and 2) schizophrenia proper which he understood as occasioned by severe problems in living that erupts abruptly even if there is evidence of patterns leading up to it over a number of years). Sullivan used the term schizophrenia to refer to the latter category, conceptualizing of it as a set of processes rather than as a clinical entity (Evans, 1996) and defining it as a failure of the self-system “resulting in a full manifestation of an autistic or egocentric personality, and regressive sleep” (Yip, 2000, p. 247).

He saw two security operations as central to psychosis: selective inattention and dissociation. Selective inattention has to do with focal awareness and the filtering of relevant from irrelevant information. It helps to mitigate anxiety by allowing the individual to avoid

perception of the source of anxiety when exposure to its source is inevitable. As the individual matures one can continue to be selectively inattentive in current relationships as an adult rather than being aware and utilizing his or her agency to confront the abuser or leave the relationship (e.g. someone who was raised by abusive parents who continues to be abused in adult relationships with sexual partners). Evans writes,

Rather than describing the situation from diagnostic terms, such as self-defeating or masochistic personality, Sullivan would focus on how, and under what circumstances, the process of selective inattention operated (1996, p. 145).

Dissociation, is employed when motivations and experiences are so anxiety-ridden that they need to be excluded from any awareness of the self, and experienced as not-me. Sullivan's discussion of dissociation as a response to overwhelming life experiences presaged contemporary theorists Judith Herman and Bessel van der Kolk (Evans, 1996). Sullivan attributed the dynamism of schizophrenia to the process illustrated in Table 1.

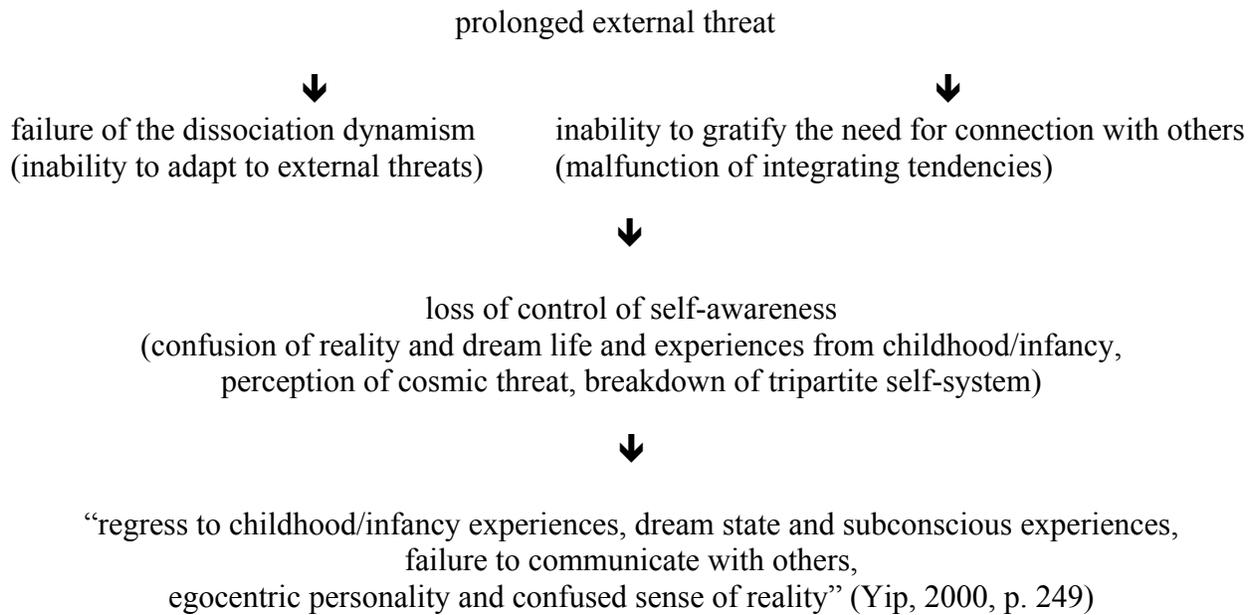


In this organization of the self-system, the individual privileges avoidance and isolation over learning and connection with others and the need for peers and the intimacy of friendship is either sublimated into fantasy or dissociated. In Sullivan's view, the "Schizophrenic individual... exhibits a disproportionate amount of dissociated aspects of the personality" (Evans, 1996, p. 151).

From his clinical experience, Sullivan gathered that upon reaching adolescence, if the need for intimacy has already been sublimated into fantasy and social isolation, once the lust dynamism comes to the fore, these security operations are not sufficient to guard against it. The self-system then deploys dissociation and selective inattention, both of which are prone to disorganization. "Loss of faith in the self, fear of the interpersonal world (primitive bad mother representations)" and over-reliance on "dissociation of needs as part of the not-me personification" (Evans, 1996, p. 151) leads to disrupted sleep in which dissociated parts emerge in severe nightmares or in nightmares from which one cannot awake. Cravings, hallucinations and delusions are manifestations of dissociated urges that come into awareness but also need to be disowned (Evans, 1996). Their content is often comprised of material from childhood and early experiences (Yip, 2000). The contents of the mind are increasingly perceived as deriving from outside the self without a sense of ownership. As these not-me and bad-me states permeate awareness, overwhelming anxiety and panic grow (Sullivan, 1962).

Sullivan believed that when an individual is faced with an untenable situation as an adult, the early experiences of childhood of denying the self come up again so strongly that there is a loss of control of awareness. When external reality is less threatening, sense of control of awareness can be regained, and lost again in frightening interpersonal situations (Yip, 2002).

Table 2: Breakdown of the Tripartite Self-System



Sullivan described this second stage of the dynamism of schizophrenia as characterized by the need to escape from unbearable anxiety in which avoidance of anxiety was privileged over interpersonal engagement to an extreme degree:

early referential processes such as autistic reverie and autistic speech rendered consensually validated experience irrelevant, allowing the person to escape the social world for the world of autistic fantasy (Evans, 1996, p. 153).

Catatonic, hebephrenic and paranoid presentations were different patterns of security operations that could be observed in the same individual at different times all of which served the same purpose of defending against anxiety. While Kraepelin believed that the individual with schizophrenia was escaping from an unbearable reality that was less pressured and therefore difficult to lure them back from, Sullivan believed that schizophrenic regression was

a nightmarish, irrational and incomprehensible world in which the menacing, primitive interpersonal experience of the bad-mother personification was omnipresent (Evans,

1996, p. 153).

He believed excessive sleep signaled the use of somnolent detachment to escape from this terror and believed that the chief obstacle to recovery was in breaching the barrier of trust to engage interpersonally again. In order to recover, it was necessary to be joined by a compassionate other who tries to understand the person's experience (Evans, 1996).

Sullivan understood paranoia as an interpersonal pattern that was related to but not synonymous with schizophrenia. He writes,

The paranoid dynamism is rooted in (1) an awareness of inferiority of some kind, which then necessitates 2) a transference of blame onto others (1956, p. 145).

Such a chronic sense of inferiority or insecurity arising from developmental misfortune predisposed individuals to reliance on this dynamism. For example, if a child is blamed by a parent for the parent's problems, the child would jeopardize the interpersonal connection and sense of belonging to the parent if he or she were to challenge the parent to validate his or her own reality. The child is left with a fundamental mistrust of others and a diminished self-esteem and a sense of fear and powerlessness. The child develops a basic confusion about what is within the self versus what's outside of it. The child has difficulty tolerating low self-esteem and as the parent shifts blame onto child, the child then shifts blame to others to reduce his sense of inferiority and anxiety. This provides an immediate relief of anxiety but also perpetuates a warped pattern of interpersonal relations that further entrenches the diminished self-concept. The effect can range from having a paranoid slant to being in a paranoid state (comprised of delusions of grandeur and persecution). A paranoid state, in and of itself, is more organized than paranoid schizophrenia. Sullivan believed that paranoid schizophrenia was indicative of the failure of the paranoid dynamism to alleviate chronic anxiety. He pointed out that most mental

disorders had a paranoid coloring (general suspiciousness, guardedness) as they are characterized by chronic low self-esteem and fear of interpersonal disapproval (Evans, 1996).

Interpersonal theory and the treatment of psychosis.

While now taken for granted, the notion of the corrective emotional experience was rejected by the classical psychoanalytic community. Sullivan was a major proponent of the potency of this aspect of the therapeutic endeavor that he explored in his innovations of milieu and group therapy. Furthermore, Sullivan's gathering of collateral data from family and significant others became a springboard for family therapy. His approach includes psychodynamic, client-centered, behavioral, cognitive and existential approaches to treatment (Evans, 1996). Sullivan's legacy in the treatment of psychosis can be summarized as:

- (1) the emphasis on the interpersonal framework including countertransference aspects,
- (2) the attempt to understand what the patient is trying to do, (3) the use of a developmental approach to psychopathology, (4) a sensitivity to the patient's self-esteem,
- (5) the prominent attention to the role of conflict and anxiety in symptom production, (6) the use of a broad multivectoral treatment effort, and (7) an attitude of tempered optimism toward the patient who is not prejudged as to his or her ability to recover or improve up to the limit of each individual's capacity (Schulz, 1987, pp. 7-8).

Sullivan felt that in order for interpersonal learning to take place in psychotherapy learning must be balanced with interpersonal security, as too much anxiety will impede cognition and encourage interpersonal avoidance. He believed that it was incumbent upon the therapist to establish security through respectful, careful and empathic listening. In this context the client can share his experience of the more fraught interpersonal relationships and correct it in the here and now. The therapist's interest in the world-view of the client is a corrective measure to the

client's experience of having to take on the world-view of others. Sullivan emphasized the here and now relationship between client and therapist, not just transference, and warned that anxiety was likely to arise on the part of the therapist in reaction to the patient. Sullivan's empathy stemmed from

an existential position arising from his belief that we were simply more human than otherwise and that we shared the same existential conditions of anxiety and isolation in our interpersonal relations (Evans, 1996, p. 171).

He encouraged a stance of 'complex empathy' for those patients who aren't able to tolerate direct tenderness (e.g. in some cases sarcasm can be received as empathy).

While empathy was a necessary condition of treatment for Sullivan, in contrast to Rogers and Kohut, it was not sufficient. The therapist also was tasked with assisting the client to modify their patterns of living so that self-knowledge and interpersonal relatedness were no longer sacrificed in the attempt to protect the self from interpersonal anxiety. Sullivan used questions to encourage clients to share their perception of self and others, how they developed these perceptions, and the distorted features of these perceptions. This included gathering a history of the client's interpersonal relations, current relations and attending to the clinical encounter. The therapist concerned himself with analysis of both verbal and non-verbal communication. Interpretations were hypotheses to be tested out with the client; and when the client judged the therapist to be wrong, the therapist then has the beneficial effect of both righting the power imbalance in the room and again serving as a corrective emotional experience of authority (Evans, 1996). Counterassumptive and counterprojective statements were utilized to balance the client's distortions of self and others. Sullivan insisted that in interpersonal psychotherapy, treatment must be tailored to fit the problem and vary with the person and the dynamism at hand,

as opposed to adherence to technical strictures in Freudian analysis as practiced by classicists. He developed the four stages of the psychiatric interview (formal inception, reconnaissance, detailed inquiry/psychotherapy proper, and termination) to serve as a guide but felt that to be truly effective, a therapist must be flexible and demonstrate “his willingness to lend his whole person to the goal of transforming the client’s interpersonal experience” (Evans, 1996, p. 176), requiring more agility than maintaining a blank screen.

As mentioned above, Sullivan warned that the blank screen and quality of silence that characterized classical psychoanalysis could be perceived as indifference by clients with psychosis and would negatively impact the relationship. Instead, therapists needed to take an active role in helping the patient speak freely without fear of judgment or reprisal or disapproval (Evans, 1996). Rather than confine the exploration of transference to Freud’s notion of “repressed erotic oedipal feelings” (Evans, 1996, p. 188), Sullivan developed the concept of parataxic distortion that recognized any sort of projecting from the past onto the future with regard to interpersonal relations. He believed that interviews should be problem-focused and structured as opposed to classical psychoanalysis that could be anxiety provoking and result in security operations.

Throughout this process, the therapist helps to ensure the client’s security by asking about and building on strengths (i.e. the client is better able to tackle bad-me and not-me if they feel grounded in the good-me). Taking a strength-based approach also avoids pathologizing the client by eliding the division between the well and the sick, and making the balance of power between the doctor and the patient more symmetrical. In this vein, Sullivan utilized the patient’s goals to direct the treatment as a reminder of who is in service of whom, and as a motivation for rigorous honesty. In his approach

the client was not a seeker to be converted to the better reality of the stronger therapist, but an individual employing an expert to assist in understanding and correcting problematic interpersonal patterns. Sullivan believed that this latter attitude led to the best interview, which reduced one-sided expectation that the answer to life's troubles resided in the psychotherapist, the client needing only to apply him or her self to the doctor's prescription (Evans, 1996, p. 185).

Sheppard-Pratt Hospital.

Sullivan was particularly interested in the dilemma facing adolescents in the heterogeneous society of the United States and the impossibility for most of realizing the American ideal. He believed that the shame and social isolation of socioeconomic difference was a significant factor influencing vulnerability to a psychotic breakdown (Perry, 1962). After two years as an assistant physician at Sheppard Pratt Hospital in Towson, Maryland, he became director of clinical research in 1925 and stayed on for 5 more years designing a unit geared specifically to young men experiencing their first or second psychotic break. Sullivan paid particular attention to the institutional hierarchy of the hospital and its effect on treatment.

to expect a patient who had suffered humiliation from his family and the world at large to find a cure in an institution riddled with outworn codes of hierarchical values seemed nonsensical to Sullivan (Perry, 1962, p. xvii).

The unit that Sullivan established ran without nurses and was not subject to the hierarchy of the rest of the institution. He hand picked attendants based on temperament and personality, and trained them to foster an accepting and warm environment (Evans, 1996). He welcomed the attendants at his home for meals and informal case conferencing, treating them as if they were part of the medical team, yet another reversal of the traditional treatment hierarchy. He believed

that the most successful of the attendants were themselves ‘potentially schizophrenic with a good prognosis’ and attributed his own skill in working with individuals diagnosed with schizophrenia to his personal experience of the ‘schizophrenic process’ (Perry, 1962, p. xvii).

Drawing from his early experiences of alienation from his pre-adolescent peers, Sullivan created the ward as an opportunity for patients to benefit from a healing experience of community, which he believed would enable them to move on from pre-adolescence to young adulthood. Sullivan intervened as little as possible in their treatment if he felt that the attendants and the social setting were satisfactorily encouraging the patient’s recovery.

Outcomes of Sullivan’s interpersonally-informed treatment of psychosis.

Over 85% of patients admitted to Sullivan’s unit at Sheppard Pratt during the 1930’s recovered as measured by return to work or home (Hornstein, 2000; Evans, 1996). These outcomes continued under his successor for several years until the program was restructured under new leadership (Evans, 1996). Psychiatrist Clarence Schulz, who studied with Sullivan, reflects,

perhaps his main contribution clinically—and, again, I cannot limit this to Sullivan alone, because others in the area, particularly at St. Elizabeth’s, thought similarly—was that schizophrenia (or dementia praecox, as it was most generally referred to then) did not follow an inevitable downhill course leading to deterioration. He found that if he and the staff could reach out to the patients, a high percentage of these patients would recover, at least from the current episode. It is my impression that his publications and consequent focus on this finding not only put Sheppard Pratt on the psychiatric map in the 1920s but also called attention to an optimistic interest in the pursuit of a treatment for schizophrenic patients which continues to this day (1978, p. 128).

Schulz's claim is evidenced by the resurgence of interest in the Soteria House model of milieu treatment developed in the 1970s by American psychiatrist Loren Mosher which drew heavily from the work of Sullivan and Laing. A Soteria House established in 1987 by Luc Ciompi in Berne, Germany continues to operate today, a Soteria opened in Alaska in 2009 (Aderhold, 2009), one is scheduled to open in Vermont in 2014, and there are efforts to establish yet another in the UK.

In her article, "Sullivan's approach to inner psychotic experiences: a case illustration" clinical social worker Kam-shing Yip describes how without a meaning-making framework her supervisee was unable to establish a therapeutic alliance with his client, resorting to pushing medication and feeling frustrated by her inscrutable behavior. Once Yip shared Sullivan's framework with her supervisee he was able to: appreciate the ways in which the client's hallucinations and delusions served important protective purposes; reflect back to her the emotional content of her experience and be empathetic; and thereby establish a therapeutic alliance that enabled interpersonal healing (2002). Yip's supervisee writes:

Before I learned Sullivan's concept of psychotic experiences, I was symptom oriented. I tried to label F's fixated delusions and hallucinations as meaningless symptoms. I did not have any interest to explore the meaningfulness behind F's odd and bizarre behaviors. I felt puzzled and confused with F's self-indulgence. Apart from pushing her to take drugs, I could do nothing. I could not establish rapport with her. She was strange, odd, introverted, and autistic. Under the supervision of our professional consultant, I began to learn Sullivan's concepts of psychotic experiences. I began to understand the meaning behind F's delusions and hallucinations. I was empathetic with F's traumatic childhood experience. I learned to listen to F's own story and explore the feelings behind her

psychotic experiences. In the past, I liked to challenge F's that her father was deceased and she had never married her husband. Later, I learned to reflect her feelings, accepted her self-indulgence and encouraged her to learn new ways to deal with her stress and frustrations. I learned to develop F's strengths and interests, so as to lessen her dependence on delusions and hallucinations. Sullivan's concepts are powerful tools for us to go into the details of F's delusions and hallucinations. His ideas give competence to understand and to intervene with clients with schizophrenia (Yip, 2002, p. 260).

This model is consistent with the strength-based approach of social work in which subjective experience of primary consideration.

Frieda Fromm-Reichmann and Interpersonal Theory

“Schizophrenia is not an illness but a specific state of personality with its own ways of living”

--(Fromm-Reichmann, 1948, p. 165)

Dr. Frieda Fromm-Reichmann, one of Sullivan's most trusted colleagues and friends, emigrated to the United States in 1935 and took a position at Chestnut Lodge, a sanitarium in Rockville, Maryland which she turned her attention to transforming into one of the pre-eminent psychoanalytic inpatient facilities and training programs in the United States, and the only private one specializing in Schizophrenia (Hornstein, 2000). She studied psychiatry and began her practice in Germany, but was forced to leave to escape the Holocaust. Her German contemporaries, some of who were taught by Kraepelin himself, believed that symptoms of mental distress had biological causes (Hornstein, 2000). However, two of Fromm-Reichmann's most influential teachers, Georg Groddeck and Kurt Goldstein, encouraged her to view symptoms as communications signals, and to let the patient's lead rather than staying true to any one particular theory of illness or treatment regimen. Goldstein viewed sickness as a relational

phenomenon, expressions of the organism's attempt to deal with demands of the environment.

“Symptoms are *answers, given by the modified organism, to definite demands*” (Goldstein, 1939, p. 18). He encouraged the stance that no matter how ‘incapacitating’ the symptoms they should be understood as active attempts by an ‘integrated organism’ to master his situation, not as meaningless reactions or ‘faulty wiring’ (Hornstein, 2000, p. 28).

Groddeck interpreted symptoms as attempts by the unconscious to communicate that the organism can no longer go on living life as usual. He believed it was the role of the doctor to interpret these symptoms, and conceptualized the unconscious as an ally as opposed to Freud's view of it as a “dangerous force that needed to be controlled” (Hornstein, 2000, p. 35).

Fromm-Reichmann's orthodox Jewish background and enduring faith were also significant influences on her clinical work. She saw her psychotherapeutic practice as a form of *tikkun*, the Jewish concept of repairing the rupture between the human and the divine, premised on the notion that the spark of divinity exists in all mankind. Like Ferenczi, she believed that all human beings have the capacity to heal, and that the failure of the healing process is the fault of the treatment, not the patient (Hornstein, 2000). Accordingly, one of Fromm-Reichmann's fundamental assumptions, in contrast to many of her colleagues, was that what patients

say and do makes sense to them, and part of it can be understood by us, just as a dream makes sense to the dreamer while dreamt [whether or not it is] understood by other or by the dreamer himself after awakening (Fromm-Reichmann, 1943, pp. 2-3).

Fromm-Reichmann believed that it was incumbent on the therapist to offer the patient hope and to help them access their innate inner ability to heal. Her sense of the therapist as midwife dovetailed with Sullivan's view of himself as participant observer, as did their shared

sensibility that the right treatment was the treatment that worked, privileging eclecticism over orthodoxy.

While Freud dismissed the prospect of psychoanalytic treatment of psychosis on the grounds that those diagnosed with schizophrenia were too interpersonally compromised to form a transference (Fromm-Reichmann, 1952), Fromm-Reichmann, like Sullivan believed that all human beings exist in a relational world, and that those experiencing psychosis were even more likely to project feelings than neurotics, resulting in an intensified transference that was less about oedipal conflicts and more about trust (Hornstein, 2000). For Fromm-Reichmann, the missive of therapy was primarily about establishing trust so that the patient felt “secure enough to give up his defensive narcissistic isolation and to use the physician for resuming contact with the world” (Fromm-Reichmann, 1939, p. 123).

Fromm-Reichmann arrived in the United States when American physicians were inclined to employ somatic treatments such as insulin, metrazol shock, ECT and lobotomy to treat all mentally ill patients, and claimed these methods to be more ‘scientific’, and thus, superior to psychoanalysis. Somatic treatments were faster and less expensive but the cost of keeping patients on locked wards for the rest of their lives was extremely high. To Fromm-Reichmann, treating someone quite intensively for a number of years so that they might live outside the institution seemed worthwhile. Like Sullivan, who she invited to give twice-weekly seminars to her staff at Chestnut Lodge from 1942 to 1946 (Hornstein, 2000), she believed that modifications to traditional psychoanalysis were necessary when working with psychotic clients, while maintaining that the differences between psychosis and neurosis was in degree, not in kind.

My experience during the last 20 years has been mainly with schizophrenic patients who came to our hospital in a state of severe psychotic disturbance, from which the majority

emerged sooner or later under intensive dynamic psychotherapy. After their emergence, they continued treatment with the same psychiatrist through the years of their outwardly more quiet state of illness, with the aim of ultimate recovery with insight. During both phases the patients were seen for four to six regularly scheduled interview per week, lasting one hour or longer. Sometimes relapses occurred.... As a rule, these relapses could be handled successfully if the psychiatrist himself did not become too frightened, too discouraged, or too narcissistically hurt by their occurrence (Fromm-Reichmann, 1954, p. 411).

According to Fromm-Reichmann, the following difficulties arose from the psychodynamics of schizophrenia: intense self-hatred; over-estimation of positive skills and destructive powers; early experience of not having been given the love and guidance he or she craved continuing as an unfulfilled yearning for love and guidance even as he or she wishes for independence; hating himself or herself for hating those whose guidance and love he or she craves; a hostility-dependency conflict that is common in most that when combined with the “implacable self-hatred” results in a qualitative difference; fear of closeness due to fear of his own hostility and destructive powers; anxiety that weak ego boundaries will be further compromised by closeness to another person; and a deficit of early learning experiences in the area of giving and receiving love. Furthermore she believed that most psychotic symptoms are over-determined, therefore there is not one meaning or one correct interpretation (Fromm-Reichmann, 1958). She writes,

How should this affect the psychotherapist’s technique? I believe that he should be resigned to the multiplicity of meanings inherent in most schizophrenic communications, and to the inevitable fact that he is lucky if he grasps *one* aspect of a cryptic

schizophrenic verbalization. If he does, he may offer his interpretation whenever he thinks it will be helpful to the patient. But he should be mindful of the fact that either he or the patient will eventually find further interpretations of the communication or symptom in question. One is just as little likely to understand the meaning of all facets of a patient's symptoms and communications as to understand all of the elements of a dream (1958, p. 3).

She implored her fellow clinicians to be slow to make interpretations, and to express their lack of understanding rather than pretending that they do, as in her experience the patient often understood more than the clinician does and would be testing the clinician's honesty and trustworthiness (Fromm-Reichmann, 1958). Fromm-Reichmann found interpretation to be distracting to those with psychotic symptoms, and waited until the end of treatment to let the patient make their own interpretations (Hornstein, 2000). She believed that rather than interpret content, therapists should seek to help the patient to understand "the genetics and dynamics of their communications" (Fromm-Reichmann, 1952, p. 96). The act of 'listening alertly' and awareness of nonverbal communication were hallmarks of her approach.

So you see, the patient took over where I was not able to do so. My not understanding her was no obstacle to useful psychotherapeutic interchange, as long as she realized that I was listening alertly, expecting her to make sense (Fromm-Reichmann, 1952, p. 98). Another aspect of Fromm-Reichmann's modification of psychoanalysis when working with patients with psychotic symptoms was her willingness to answer the patient's questions about her so that they could decide if they wanted her as companion in their treatment journey, and avoiding the ominous effects of the therapist as a blank screen (Hornstein, 2000).

Building on Freud's view of schizophrenia as a regression to the early development in

which relationships were experienced as threatening and scary, Ferenczi, Sullivan, Franz Alexander, and Fromm-Reichmann saw the relationship with the therapist as a ‘corrective emotional experience’—Franz Alexander was the first to call it this—whereby the therapist bears witness to patient’s experience and in this way begins to lessen their feelings of isolation and alienation and in this way fosters a healing process (Hornstein, 2000).

Fromm-Reichmann described psychosis as terror that had not been verbalized and that was all the more difficult to verbalize in the context of family. Repressing feelings of rage or terror at one’s family endangered the child’s capacity to form relationships in the future (Hornstein, 2000). She understood symptoms as an expression of and a defense against unrecognized excess anxiety whereby the patient with psychosis is simultaneously a regressed infant and of his/her actual age who is bewildered by his symptoms and the underlying anxiety and plagued by fear of his own destructive capacity, a fear “which he acquired in response to repetitive, early interpersonal traumata, and which he abhors as much as and more than his environment” (Fromm-Reichmann, 1952, p.102). Treatment required the therapist to relate to the adult part of the self in the attempt to enable the patient to recognize the manifestations of his illness in his relationship with others and with the analyst, and to see his symptoms as a result of his anxieties and his defenses against them (Fromm-Reichmann, 1952).

The inpatient setting allowed patients to regress to the point at which the psychopathology could be exposed, whereas in outpatient treatment, the process is compromised by the patient’s expenditure of energy to suppress the pathology to keep up appearances. Fromm-Reichmann and her colleagues believed that allowing the ‘fever to run its course’ made it possible to be worked through with the therapist. The hospital setting functioned as a holding

environment where structure was predictable and reassuring rather than punitive. Fromm-Reichmann believed that most individuals experiencing psychosis had had chaotic childhoods and the well-reasoned structure of an inpatient program helped to provide a corrective emotional experience (Hornstein, 2000).

As mentioned in Chapter Two, Fromm-Reichmann strongly emphasized the role of countertransference when working with patients diagnosed with schizophrenia. She contended that patients could sense when their clinicians were afraid of them, and that it was the clinician's responsibility to work through this so that they were not too consumed by their own fear to focus on their patients' feelings of fear and humiliation. Fromm-Reichmann felt that one of the chief obstacles to successful treatment of schizophrenia was the therapist's unwillingness to confront their own terror of loneliness.

The fear of loneliness, the fear of being enveloped by that nameless state, may be what really makes people afraid of schizophrenic patients, makes them think of these patients as 'out of this world' or as a different species than the rest of us (Fromm-Reichmann, 1990, p. 329).

In order to support clinicians with this intensified countertransference common when working with extremely emotionally distressed patients, Chestnut Lodge was conceived of as a therapeutic community in which the nurses and the doctors were in analysis as well as the patients. Fromm-Reichmann believed that it was this work that would enable the therapist to take the patient's pain seriously, so that they would not need to manifest their pain further through symptoms of mental illness (Hornstein, 2000).

In the treatment relationship, Fromm-Reichmann warned that fear of closeness needed to be accounted for along with fear of loneliness, and that therapists must not fall prey to the

temptation of trying to extend a nonprofessional friendship as the basis for the therapeutic relationship. Her experience of her patients was that they had a heightened sensitivity to feigned closeness. She wrote,

Closeness in the present entails the danger of rebuff in the future to the early traumatized schizophrenic. Also, he will not be able to hide his "ugliness," his "meanness," his hostile and destructive impulses, from a person who comes close to him (Fromm-Reichmann, 1952, p. 105).

Closeness also exacerbated the patient's anxiety about losing a sense of the boundary between him or herself and outside world. Her perception of the tenuousness quality of the patient's relationship to his or her own identity was reflected in her recommendation that clinicians assist the patient in finding the internal thru-line present in sickness and in health to assuage their fears that recovery signifies disappearing. She urged clinicians to be clear that they wouldn't take away a person's symptoms—which are also their defenses—but that the patient might no longer wish to have these symptoms once they have a better understanding of their anxiety (Fromm-Reichmann, 1952).

At the conclusion of treatment, Fromm-Reichmann asked for her patients' insights into their treatment and how it was given, from the relationship with the individual therapist to their overall experience at Chestnut Lodge and changes were made based on these insights (Hornstein, 2000). Upon analysis of Clarence Schulz's "A Follow-Up Report on Admissions to Chestnut Lodge," (1963) which relied on surveys and narrative evaluations from 226 of 302 patients admitted between 1948 and 1958, Hornstein reflects that the study

...revealed enormously positive feelings on the part of many patients. More than 200 of his participants took the time to write narrative responses; they assumed (correctly) that

such evaluations would be interpreted with the same attention to nuance as everything else at Chestnut Lodge. None seemed surprised that their views were being solicited, testimony in itself to the regard patients obviously felt. What stands out most from these responses is the number of patients who praised the lodge (2009, p. 294).

Of the 226 respondents who provided narrative responses, 75% were ‘seriously disturbed’ during their stays and reported positively about the experience. Ninety-eight of the 226 previous residents who provided narrative responses had diagnoses that could be ‘reliably identified’. Of these 98 individuals, 63% were diagnosed as psychotic; and 13% were diagnosed with severe personality disorder (Hornstein, 2000, p. 432) While these outcomes are subjective, and might not meet mainstream criteria for evidence-based practice, one could make the case that it is the very strengths of Fromm-Reichmann’s approach—flexibility, pragmatism and intuitiveness—that resist manualization and the uniformity of practice necessary to conform with standard measures. Given her flexible, intuitive and pragmatic approach to treatment, Fromm-Reichmann had difficulty codifying her methods. Fromm-Reichmann’s therapeutic approach was by definition “idiosyncratic to each case... an art but also a philosophy of listening to the patient” (Hornstein, 2000, p. 148).

Psychiatrist Anne-Louise Silver worked at Chestnut Lodge from 1976 until it closed in 2001. She has continued to be a staunch advocate for the efficacy of psychodynamic treatment for psychoses, and is Chair of the Washington, DC branch of the International Society for Psychological and Social Approaches to Psychosis. In her writings and lectures she has repeatedly called attention to her experience that treatment at the Lodge was more effective when patients were not treated with neuroleptics (Sinason and Silver, 2008).

I had the good fortune to work at Chestnut Lodge both in the era when medications were

not used, and in its final two decades, when medications were used heavily. In the earlier era there were patients who arrived grossly and chronically psychotic; on completion of their treatment their psychological testing revealed no trace of psychosis. While this had not been the rule, this did not happen in the medication years (Silver, 2003).

Bertram Karon.

Co-author of the classic work, *Psychotherapy of Schizophrenia: The treatment of choice*,

Bertram Karon has been a staunch advocate for the efficacy of psychodynamic treatment for schizophrenia since the 1970s. He and his colleague Gary VandenBos, conducted an important study in 1981 challenging the notion of schizophrenia as an organic incurable degenerative disease, and evidencing the efficacy of a meaning-making approach without the use of neuroleptics. Karon describes his approach as derivative of ego psychology (Sigmund and Anna Freud, Erikson, Sterba and Bettelheim), interpersonal theory (Sullivan and Fromm-Reichmann), object relations theory (Fairbairn and Guntrip) and affect theory (Tomkins) (Karon, 2008).

According to Karon, schizophrenia is a state of terror. He writes,

Human beings are not easily able to tolerate chronic, massive terror. All of the symptoms of schizophrenia may be understood as manifestations of chronic terror or of defenses against terror. Chronic terror tends to mask other feelings. Nonetheless, the schizophrenic frequently experiences, in addition to fear—continuously or intermittently—anger, hopelessness, loneliness, and humiliation. “Inappropriate” affect is usually socially inappropriate, not inappropriate to the patient's inner experiences (2003, p. 7).

From Fromm-Reichmann’s assertion that those who experience catatonic symptoms can hear and see all that is occurring but believe they will perish if they move (Fromm-Reichmann, 1947) Karon concluded that catatonic symptoms were none other than the universal strategy used by

animals to respond to the fear of predation (2008). Like Sullivan and Fromm-Reichmann, Karon conceives of symptoms as having their basis in interpersonal relations. He postulated that auditory hallucinations are more common than visual hallucinations because deafness cuts one off from others more than blindness (Karon, 2003). He believed that delusions were based in the need for a systemic explanation of the world and of the self, necessary to all humans, however, in these cases, the experiences that needed explaining were themselves highly contradictory and unusual. For example, if one learns from their family that

... love means 'I hurt you and try to kill you from time to time,' it is very difficult (and terrifying) to try to establish a close and loving relationship with another human being (Karon, 1989a, p. 178).

As were Fromm-Reichmann and Sullivan before him, Karon is invested in demonstrating the method to the madness, and redefining madness as a reasonable attempt to deal with untenable circumstances rather than locating the unreasonableness within the individual.

Schizophrenic people have had strange experiences. In part, their symptoms are strange experiences. In addition, their lives often include unusual real events. Therefore, their systematic explanations of their world seem strange. But they demonstrate a need to be as realistic as their anxieties permit. Insofar as discrepancies between their understanding and reality become apparent to them, and as dynamic balances change, the patients continually revise their understanding... Because the paranoid system is not an abnormal process, but a normal process used to cope with unusual problems, it is possible for a nonfrightened, nonhumiliating therapist to share the patient's systematic understanding, to respectfully call attention to inconsistencies, and to helpfully supplement the patient's understanding with the therapist's knowledge of the world, of other people and, more

importantly, of the workings of the human mind (2003, p. 22).

As in any psychoanalytic therapy, the therapist's task is to work with the client to make the unconscious conscious and to consciously reconnect the "symbolic act (or symptom) with the original traumatic material" (2003, p. 17). He believes that goal of therapy is to provide a corrective emotional experience and symptom reduction achieved by consciousness of the meaning of those symptoms and the connection between the past and the present (Karon, 2008).

As in any therapy, what changes the patient is the internalization of the therapist as well as the insights gained. The patient internalizes the therapist into the superego, so that the patient treats him or herself in the kindly, rational way the therapist would instead of the rigid, punitive way that most patients treat themselves based on their early identifications (Karon, 2008, p. 9).

He pointed out that rather than forming a transference to an individual, those with schizophrenia form a transference "to the world at large," the challenge for Karon is how to form a transference that is therapeutically usable (2003, p. 2).

Karon's technique.

Karon saw patients 6 or 7 days per week at the onset of treatment and then went down to 3 times per week (Karon, 2003). He contends that the treatment of choice for schizophrenia is psychotherapy without medication.

Medication as an adjunct makes behavioral control easier to attain but slows down the rate of underlying change. This is because medications damp affective responses, which is helpful to the patient. But affective responses during the therapy session are also a part of the process of change (2003, p. 17).

Furthermore, as both he and VandenBos have pointed out, one of the problems of using

medication with patients is that therapists then discredit their work with the patients, and don't believe in the power of words (Karon & VandenBos, 1998).

Karon believes it is a mistake to use the first session with a patient to get a detailed history. He advises that it is important to do something that the patient experiences as helpful in the very first meeting so that one is experienced as a giver and not a taker (VandenBos, 2008).

The therapist must give a feeling of strength in the sense that you are willing and able to deal with anything and go anywhere the patient needs to go, no matter how scary. If you know things that will help the patient with the patient's current concerns (not yours), you let them know. The patient is often surprised that you have anything to offer that actually helps, that you care about what they are afraid of, and that you listen carefully and take seriously what they say (Karon, 2008, p. 5).

As was true with Sullivan and Fromm-Reichmann, Karon believes it is important for the therapist to demystify him or herself, as ambiguity would most likely be "filled by the patient with negative transference" (Karon, 2008, p. 5). For this reason, he sat within the patient's view and worked to be "helpful, not neutral" (2008, p. 5). While crucial that the therapist demystify her own intentions, the therapist must also work to tolerate the ways in which she is mystified by the client.

Typically, psychotic patients do not trust you. You cannot expect a psychotic patient to tell you everything they understand. They are afraid that anything they tell you might be used to hurt them. That is why it is essential to tolerate not understanding as well as to try to be helpful (Karon, 2008, p. 5).

Toleration of not knowing is one of several key challenges that arise for therapists in the treatment of individuals with psychosis. However, Karon also draws our attention to the difficulty involved in knowing.

We do not want to know about schizophrenia because we do not want to feel such intense terror. Given enough stress, all of us have the potential for schizophrenic symptoms; the differences in vulnerability seem to lie in the quantity and quality of the necessary stress. The severity of the stress is usually determined by its conscious and unconscious meanings (Karon, 2003, p. 7).

In order to offer effective treatment for individuals experiencing psychosis, therapists must be willing to feel the precariousness of balancing between fear and loneliness.

Sometimes the therapist may, all too successfully, empathize with the schizophrenic patient's terror and withdraw from the patient (Karon, 2003, p. 7).

With this in mind, Karon cautions that over-reliance on medication can be understood as stemming from the providers need to manage their own anxiety (2003).

In addition to Karon's literature reviews on the subject of the efficacy of the psychodynamic treatment of psychoses (1989b; 2003), in 1981, he and VandenBos conducted the Michigan State Psychotherapy Project. Patients who had been diagnosed with schizophrenia were randomly assigned to three groups: a) 70 sessions of psychoanalytic psychotherapy; b) pharmacotherapy; or c) a combination of the two.

...blind evaluation showed that psychotherapy alone, or with initial medication that was withdrawn as the patients could tolerate it, led to earlier discharge from the hospital, kept the patients out of the hospital, and improved their thought disorders more than medication did, and the patients lived a more human life in a variety of ways. Psycho-

therapy with maintenance medication was better than medication alone, but not as good in the long run as psychotherapy alone or with initial medication that was withdrawn. Because of the hospitalization and particularly re-hospitalization findings, psychotherapy was much less expensive over a four-year period than traditional treatment with medications (Karon, 2003, p. 7-8).

Patients who received psychotherapy spent half of the time as Group C in the hospital during the two years after treatment and patients who didn't receive therapy had a 2 to 1 chance of being re-hospitalized (Karon, 1989b). The researchers also found that the experience level of the therapist had a strong impact on treatment outcome, the more experienced the therapist, the better the outcome. According to the follow-up study, 75% of patients who solely received pharmacological treatment were on public assistance in contrast to those who were offered psychotherapy, 33% of whom were receiving public assistance (1989b). The follow-up study demonstrated that psychotherapy offers long-term savings making it less expensive than pharmacological treatment (1989b).

Davidson, one of Karon's critics has questioned whether the psychoanalytic aspects of the treatment had anything to do with its success, suggesting that it may be the relational aspect of his practice (24-hour availability, a six-day per week treatment schedule, longevity of the treatment relationship, willingness to leave the room to accompany the client to the diner or school) rather than insight that enables interpersonal health (2008). However, it seems like an impossible task to separate the psychoanalytic from the relational, when the act of joining together in a meaning-making endeavor is a relational practice, offering a resonant interpretation at the right moment, is by definition, an act of attunement. As Stolorow writes:

The analyst's transference interpretations, in other words, are not disembodied

transmissions of insight about the analytic relationship; they are an inherent, inseparable component of that very bond (1993, p. 35).

Intersubjectivity and conceptions of schizophrenia

The Washington-based interpersonalist approach of Sullivan and Fromm-Reichmann was a primary influence on its New York branch, the William Alanson White Institute, home to today's relational school of psychoanalysis (Sinason & Silver, 2008). Sullivan conceptualized of the personality as developing through interpersonal contact, or as subjectivity developing from intersubjectivity.

[Sullivan] identifies the exchange of emotional tone between mother and infant, which he calls empathy, as the formative relational context in the development of subjectivity through intersubjectivity (Bradfield & Knight, 2006, p.3).

Both the relational and intersubjective schools of psychoanalysis critique what Stolorow and Atwood have termed “the myth of the isolated mind” (1992, p. 9), the privileging of intrapsychic mechanisms in the absence of the developmental and present moment impact of the relationship world with particular attention to the bidirectional dynamics of the clinical dyad. Or, as Benjamin has put it,

The intention of relational theories has been to conceptualize the effects of human relationships on development, as seen in connection with intrapsychic mechanisms (1999, p. 34).

In these schools, the space between therapist and patient is alternately referred to as the intersubjective field, the analytic third, potential space, transitional space, the analytic object, Kimura's concept of *aida* (Rulf, 2003) and the relational matrix (Ringstrom, 2010). Neither the

relationists nor the intersubjectivists

adhere to a linear, cause-and-effect model but recognizes that members of any social system perpetually mutually influence one another in a nonlinear, circularly causal manner (Ringstrom, 2010, p. 198).

Both the intersubjective and relational schools embrace the concept of “perspectival realism” in which all participants in the intersubjective field have access to a unique if overlapping perspective, and that it is in the sharing of these viewpoints that a more whole truth is grasped (Ringstrom, 2010). Another commonality between these two schools is their experience-near sensibility that the therapist must attempt as much as possible to empathize with and understand the subjective experience of the patient, as well as to plumb the depths of their own experiences to access both points of connection, and awareness of the limitations of their understanding (Ringstrom, 2010). However, the intersubjectivists take their critique of Cartesian psychoanalytic concepts a step further than the relationalists, objecting to all terminology that retains notions of individual pathology and distinctions between the interpsychic and the intrapsychic, claiming that subjectivity is contextually determined and ever-changing (Ringstrom, 2010; Orange, Atwood & Stolorow, 1997). Laing and the anti-psychiatrists anticipated this theoretical shift, arguing that psychopathological process is intersubjective in nature, and the self is constituted by interactions with others in a continuous and fluctuating process (Laing, 1961). Intersubjectivity takes place in the I-You or second person dimension negotiated through the pre-verbal intuitive process of attunement (Stanghellini & Lysaker, 2007).

It is important to note that the relationalists and the intersubjectivists utilize differing conceptions of intersubjectivity. The former define intersubjectivity as the emergent developmental capacity to view the other as a self in its own right, where as the latter views the

intersubjective field as neither

a mode of experiencing nor a sharing of experience. It is the contextual precondition for having any experience at all (Orange, Atwood, and Stolorow, 1997, p. 85).

If the self is defined by inter-relatedness or intersubjective relatedness, and if in withdrawing from relation with others, one's relationship with self is also compromised (Bradfield & Knight, 2006), what does this mean for those diagnosed with schizophrenia, a condition characterized by a lack of interpersonal relations?

Phenomenological psychiatry.

Phenomenological psychiatry (as practiced in Europe, North America, Japan and South America) has emerged from the works of phenomenological philosophers Husserl, Heidegger and Merleau-Ponty and is primarily concerned with the subjective experience of psychiatric disorders aiming “to narrate the individual's being-there, in the Heideggerian sense of the *Dasein*, and their being-with, in the sense of the *Mitsein*” (Bradfield & Knight, 2006, p. 36). This project seeks to make the unintelligible intelligible, to both inform clinical practice and, to enable the therapist to empathize with the client—without which therapeutic activity cannot occur.

Phenomenology also seeks to describe the meaningful organization of a person's experiences, expressions, and behaviours, pointing to the individual's *narrative understanding*. Narrative understanding brings together the scenario of action with that of consciousness to make sense of the others' behaviours and expressions. Narratives are synthesizing schemes of comprehension that confer a unifying meaningfulness to seemingly disparate phenomena. This means that narratives are connections between one person's perceptions, emotions, motivations, desires, beliefs, values, and a given action. They are not deterministic cause-effect explanations, but *probabilistic connections*

(Stranghellini & Lysaker, 2007).

North American Existential phenomenologist L. A. Sass in particular has sought to challenge the prevailing psychiatric discourse that suggests Schizophrenia is “beyond the pale of normal human experience and empathy” (Rulf, 2003, p. 27) and to dispense with the notion of its “unbridgeable alienness” (Sass, 1994, p. 78). Based on his attention to the subjective experience of those diagnosed with Schizophrenia, Sass rejects the dichotomy of positive and negative symptoms, and instead conceptualizes of it as a state of hyper-reflexivity.

...he highlights the contradiction between the schizophrenic’s constant need to think and his constant inability to understand, emphasizing the close connection between the exaggerated involuntary introspection and the “loss of natural self-evidence” (Rulf, 2003, p. 27).

The privileging of subjective experience also allows the field to be guided by what the client is most concerned about, rather than the other way around. In a 1998 study (Parnas, Jansson, Sass, and Handest), 70% of participants in the midst of their first psychotic break reported that they were far more distressed by their disturbed experience of self (feeling cut-off from others, feeling that they are living their lives in the third person, loss of agency, erosion of boundaries between self and not self, perception of intense vulnerability to intrusion) than they were about their psychotic symptoms.

Loss of a shared reality.

The phenomenologists describe Schizophrenia as characterized by “an awareness of self as interrupted and discontinuous” and “a process of becoming estranged from being with, in which the establishment of relationships with others becomes a difficulty” (Bradfield & Knight, 2006, p. 36). They suggest that Schizophrenia entails the collapse of the automatic and

“...non-egoic intentional processes that constitute the world and the empirical subject... a dissolution of primordial certainties with respect to essential traits of objects in the world, including the self (Rulf, 2003, p. 7).

Interestingly, the phenomenologists point to the Greek concept of *epoché* (ἐποχή “suspension”) is to illustrate a shared existential quality between the philosophical perspective and the perspective of those experiencing psychosis (Rulf, 2003). *Epoché* captures the notion of the moment where all certainties about the self, the world and action in the world, is suspended and in which one’s own consciousness can be freely and rigorously critiqued so that a more grounded system of beliefs may be established in its place (*Epoché*, 2013). However, while the philosophers intentionally and willingly aspire to this state of suspension of shared belief in reality, the thesis of reality is unwillingly suspended for the patient for whom the shared world becomes unreal (Rulf, 2003).

While both phenomenologist and schizophrenic have left behind the “natural attitude” with its strong attachment to everyday experience and the self-evident, taken-for-granted quality of experience, the process and result differ widely. Whereas the researcher must overcome great resistance in order to capture a fleeting moment of the transcendental reduction, the schizophrenic is, so to speak, left stranded in it as if in a foreign planet from which s/he is unable to return (to the natural attitude) (Rulf, 2003, p. 34).

Stanghellini and the Lysaker brothers conceptualize of the loss of a shared reality in terms of a crisis in attunement, and the concomitant inability to experience first and second-person awareness.

The experience of connection with others can only be experienced as if from outside of the relationship (i.e. from the third person). In schizophrenia the social world thus loses

its characteristic network of relationships among embodied selves moved by emotions, and turns into a cool, incomprehensible game (from which the person feels excluded) the meaning of which is sought through the discovery of abstract algorithms and elaborate impersonal rules (Stanghellini & Ballerini, 2004).

The loss of the relative.

Another existential quality of schizophrenia, as described by the phenomenologists, is the difficulty in tolerating the ambiguity of shifting between the relative and the absolute and getting stuck at one extreme or the other, in which one is either all-powerful or completely powerless (Rulf, 2003). According to Rulf, Blankenburg described hebephrenia as pervasive relativity and delusion as the primacy of the absolute. The individual experiencing delusion loses their facility to entertain and navigate between multiple perspectives.

Either a) s/he does not dispose of the auto-mobility necessary to detach from her/his own and place her/himself in another's shoes, or b) when s/he places himself in the other's view (regard) it is not in a free, active and instrumental way, but rather in a pathetic fashion, feeling the weight of the other's look upon her/him as omnipotent, remaining paralyzed in/by it. The feeling of "being watched" by the others' intentionality potentiates his own intentional paralysis (p. 13).

Autistic self-encapsulation a defense against the perceived omnipotence of others whereby eye-contact is experienced as an intrusion. Delusions and hallucinations also are understood as a buffer against loneliness, a substitution for a threatening and potentially annihilating intersubjective reality (Rulf, 2003). Sass has proposed that delusion is not a matter of mistaking the imaginary for the real, but mistaking the real for the imaginary, in that the derealization of the world makes it appear uncanny and without substance (1994). He argues that the

disengagement and hyper-self-consciousness that typifies schizophreniform disorders unlike regression to infancy, requires the cognitively sophisticated stance of a skeptical observer, and that it is the internal rather than the external world that is given ontological primacy “involving a cerebralization of instinct and the body, rather than a libidinization of thought” (p. 95). Delusion also is described as an unconscious attempt to construct certainties where there are none:

While the normal subject is always immersed in intersubjectivity and thus seeks the clues to his future in himself, his needs and competence, the autistic subject, because unframed by intersubjectivity (and therefore not perceiving himself truly as self or agent) is forced to look for guiding clues (omens) in the outer world, which renders the world potentially self-referential. If submitted to too heavy demands or stresses, such a person may attempt to escape the threatening context by reshaping the world through delusion (Rulf, 2003, p. 14).

Intolerance for the reflecting self.

Phenomenologists describe a pre-conscious and pre-verbal unity of subject and object—or of the thinker and the object of thought. Reflection threatens this unity. Kimura has explored the ways in which this internal experience of difference in Schizophrenia. Rulf writes:

While in classic depersonalization, external reality and the sense of existing of the world disappear together with the inner sphere, this is not the case in schizophrenia. In this case, the Self as relationship or difference with oneself has not vanished, but has acquired the specific character of “being other”. At times it may be the other of mindreading, of persecution, observation, or influence, at times simply the other of alienation, of being other than the others. If the alteration touches the reflecting self, one can easily imagine how this could lead to the central idea of paranoid delusion: Feelings of being observed

by others, in this case represented by the estranged reflecting self. On the other hand, if the reflected self becomes estranged while remaining subject of the will (sujet de la volonté), it can happen that the self senses a strange subject invading its most intimate sphere, thus experiencing the self as under the influence of another... the distinctive mark of schizophrenia is that the intersubjective coherence between the person and the others in his surroundings is permanently in a critical situation. He speculates that this permanent crisis may be at the origin of the propensity to excessive reflection as a means of reestablishing the threatened self. Kimura reaches a tentative conclusion; the specific trait of schizophrenic reflection is that it is not the other (der Andere) but otherness itself (das Andere) which appears as the other self in the person's consciousness (2003, p. 29-30).

Blankenburg explains the difficulty in integration of the reflecting self somewhat differently. He suggests that the problem occurs when an individual is unable to use doubt constructively, but instead feels overwhelmed by it and is unable to maintain her sense of belonging in the world at a pre-verbal/conceptual level of being.

As a consequence there is a pervasive sense of alienation and disengagement ("loss of vital contact") accompanied by an acute sense of existential threat and fragility at being exposed, so to speak, naked to the world and others- a condition Laing (1965) called "ontological insecurity" (Rulf, 2003, p. 39).

Intersubjective vs. relational approaches to treatment of psychosis.

Atwood, Orange and Stolorow contend that the Cartesian construct of a discrete self does not account for the subjective experience of psychosis:

Experiences of extreme self-loss and of the disintegration of the world cannot be

conceptualized within such an ontology of mind, because they dissolve the very structures this ontology posits as universally constitutive of personal existence (2002, p. 282).

Atwood, Orange and Stolorow proceed to point out that psychosis is defined by the notion of a departure from an objective reality, an objective reality that according to intersubjectivity and postmodern philosophy, does not exist.

Viewing psychological annihilation in the context of an intersubjective field means that this experience is interpreted as occurring within a living system of mutual influence. The visible manifestations of the experience are therefore not seen to emanate from a pathological condition localized solely within the patient; nor, however, are they regarded simply as reactions to a primary victimization at the hands of others. Such unilateral conceptions, emphasizing an exclusive determination either from the side of the patient or from the side of the human environment, fails to take into account the complex transactional process occurring between the two... Sometimes persons undergoing the experiences described here are viewed as carrying a special vulnerability or even predisposition that is then seen as a determinative factor in the genesis of personal annihilation. The problem with such an idea is that it represents a return to Cartesian and objectivist thinking, within which factors somehow located “inside” an individual—in his or her mind or brain—become operative causes in the unfolding of subjective states. We then have a picture of an isolated mind, containing predisposing sensitivities and vulnerabilities, which collapses in the face of objective external pressures of some kind. In an intersubjective framework of understanding, there are no fully isolable vulnerabilities that exist inside anyone, because what appears or does not appear as a

vulnerability only materializes within specific intersubjective fields (2002, pp. 288-89). Atwood et al. argue that those operating from a Cartesian view interpret the lack of obvious catastrophic events preceding a psychotic state as evidencing an intrapsychic or biological cause rather than a relational one. Such a conclusion

fails to take into account the unique meanings that seemingly ordinary or even trivial occurrences may take on in the intersubjective field to which they belong. This context sometimes includes profound, ongoing issues of world formation tracing back to the vicissitudes of early life, issues touching on the person's very capacity to experience "I am" (2002, p. 304).

To suggest that to correct the client into a first person perspective is a failure of attunement, and that instead, the therapists should accept the patient's experience of themselves in the third person and speak to them accordingly, and in so doing refrain from assuming and imposing a 2nd or 1st person point of view onto them. It is in this act of attunement, they contend, that the patient will begin to feel glimmers of having been recognized and known, and to make contact with their own existence alongside their feeling of nonexistence.

While the relationalists seek to affirm the subjective experience of the client, they do not privilege attunement to the same degree as the intersubjectivists. Their contention that implicit knowing must often be enacted in order to be available for analysis is in stark contrast with the intersubjectivists' position.

For the Relationalists, enactments fill in for that which attunement alone is unlikely to illuminate. This is in part accounted for by their belief that that which must become enacted involves dissociated self-states often inaccessible to attunement... Prior to therapy, some self-states are simply incommunicado with others. It's not so much that

they are in conflict as it is they don't even recognize one another—there are no access codes between them—so to speak. This is quite different from the ongoing “war” of the dynamic unconscious that attempts to manage conflicts that are prospectively accessible to consciousness through the “return of the repressed.” By contrast, because dissociated self-states exhibit little capacity to recognize other dissociated self-states they must be enacted to become recognized (Ringstrom, 2010, p. 210).

Dialogical conceptions of self.

Dialogical theory has grown out of Bakhtin's assertion that the self is composed of multiple voices that together comprise a coherent, yet composite, self (Bradfield & Knight, 2006). The changing interpersonal context enables movement between self-positions and determines which self will be dominant. The better an individual's capacity to move between self-positions, the more coherent their narrative of self will be. In this conceptualization of subjectivity, Schizophrenia is understood as a state of narrative incoherence in which the harmony of polyphonic voices disintegrates into cacophony (Lysaker & Lysaker, 2005). The interpersonal context requires that individuals are able to maintain internal dialogue between self-positions. In experiences of psychosis, these multiple self-positions are both perceived as potentially annihilating, and, as an intrusion by the other. In other words, entertaining more than one way of thinking and being comes precariously close to the fragmentation of the self. According to dialogical theory, disintegration of the self can occur as either: 1) internal cacophony, when self-positions are organized in a way that impedes a functional response to interpersonal experiences, or 2) monologue, when multiple selves are forcibly reduced to the monological self (Bradfield & Knight, 2006). In this instance, one or several self-positions would become dominant, limiting the individual's capacity for internal dialogue (Lysaker &

Lysaker, 2005). Dialogic practice is central to the social network approach of Open Dialogue, which will be the subject of Chapter Six. The current chapter explores dialogic theory and practice in the context of individual psychotherapy.

Stanghellini and Lysaker, two proponents of dialogically-informed approaches to treating individuals diagnosed with schizophrenia argue that CBT's focus on dysfunctional cognitions and psychoanalysis' focus on inner conflicts perpetuate a 3rd person viewpoint, and that both endorse an intrapsychic conceptualization of the problem rather than a problem of intersubjective engagement.

...we focus on the promotion of the experience of self in the second person as a necessary first step to change. In contrast to cognitive and psychoanalytic views, our approach highlights the inability to share a view of oneself in the second person with others as a major root of vulnerability to schizophrenia (Stanghellini & Lysaker, 2007, p. 170).

In this approach, the emphasis is on (re)building the patient's capacity to participate in intersubjective space with a focus on the here and now of the relationship based on the premise that it is the loss of this ability that causes the pain from past experiences or inner conflicts to fester; as opposed to operating on the premise that resolution of inner conflicts or the righting of cognitive distortions is what will allow the individual to again participate in the intersubjective realm (Stanghellini & Lysaker, 2007).

Therapeutic method.

Lysaker and Daroyanni question how it was possible for Karon, Sullivan and Fromm-Reichmann to establish relationships with their clients when compromised interpersonal function is a basic tenet of schizophrenia (2006). They speculate,

perhaps deeply meaningful relatedness in the psychotherapy of schizophrenia is possible

because the patient is sharing not the therapist's perceptions of things in their own right, but the therapist's capacities to shape and organize their perceptions (p. 56).

Lysaker and Daroyanni outline an integrated psychotherapeutic approach with particular attention to relatedness. For example, upon noticing the patient's anxiety and fear of vulnerability at the beginning of each session, the therapist offered the patient sympathy rather than empathy, believing it to be the less presumptuous of the two, and inviting the patient to share his subjective experience to be jointly considered in the intersubjective space. In cases when the patient fails to filter between relevant and irrelevant material, the therapist can suggest one or more meanings as a way of organizing the material or invites the patient to order the material by asking what are you now telling me about yourself, or "what are you telling me now that you want me to know about yourself" (p. 61). When the patient has difficulty linking the present conversation with past conversations, the therapist offers the patient a sense of narrative coherence (a continuous self) by quoting the patient's language and concepts from previous sessions. After analyzing sessions, Lysaker and Daroyanni found that relatedness between client and therapist was engendered by

the therapist's attitude of sympathy followed by assistance filtering, recalling and considering in a flexibly abstract manner material relevant to the patient's condition. This appeared to make intersubjectivity possible in the session and the patient was able to accept therapist reflections of him in the second person (e.g., "you feel X . . .") with profound and deeply moving ends (p. 62).

A therapist should base their approach on whether the person's self-organization is barren, monological or cacophonous (Lysaker & Lysaker, 2011). In the case of the barren self as evidenced by the absence of internal or external dialogue, the therapist must avoid supplying the

narrative for the patient.

authoritative accounts of clients' lives could confirm their emptiness and performatively situate them in a role of passivity, missing the point that barrenness results more from incapacities to create life-narratives amid the interanimating play of self-positions than from a deficient amount of thematic material (p. 128).

In this regard, you-statements (e.g. you are remembering the walk you took by the lake) develop the client's capacity to experience themselves as an agent in their own life.

One might even say that that they find their "I" in the structural entailments of the singular "you" to which they respond (p. 129).

In the case that a therapist is working with a client with a monological self-organization (the client believes they are Martin Luther King, Jr.) the therapist can focus the discussion on the way that this one thought or belief occludes all other thinking, enabling the client to see this thought as a thought, and in so doing, to gain some distance from it:

... clients may be able to see themselves as persons who are not merely the subject of monological themes but beings who can think about their own thinking and engage in a range of different forms of self experience (p. 130).

Cacophonous self-organization often manifests as an individual saying many things at once which appear unrelated to each other, and are often phrased in the 3rd person or as abstractions. This can be understood as the voicing of many self-fragments, which the client does not necessarily feel ownership of. To foster polyphony the therapist can reflect these fragments back to the client, with one modification:

Purcell noted that people in general are angry and not to be trusted. In reply, the therapist noted: "You're angry," and then "You are not to be trusted." Shortly thereafter there

were comments that the therapist could not follow, followed by the claim that people in general shun the wounded, to which the therapist replied, “You are shunned.” Purcell then said: “The head of the body is in pain.” And the therapist said in return: “You have a headache” (p. 131).

As the client recovers his sense of ownership of these ‘self-fragments’, the therapist then assists the client with the synthesis of these fragments and the client’s capacity to tolerate these multiple aspects of himself continues to develop. This is in part evidenced by the client’s recovered ability to speak in the first person and view himself as the protagonist of his own story (Lysaker & Lysaker, 2011). In this way the therapist assists the client in recovering his agency, or what Merleau-Ponty terms as the intentional arc:

Psychotherapy may serve as a "dialogical prosthesis" to help re-establish the lost connection between bodily feelings (emotions) and interpersonal situations. The task of the therapist is promoting the construction of micro-narratives focused on real world situations (especially here-and-now, You-and-I situations) (Stanghellini & Lysaker, p. 174).

While allowing that schizophrenia can worsen and be worsened by pain, the Lysaker and Daroyanni reject the notion that trauma causes schizophrenia, and critique Karon’s presumption that Schizophrenia is a state of terror, and instead suggest that one can’t assume what subjectivity is; that countertransference doesn’t help one to divine the internal conflicts of the patient but allows the clinician to remove his own debris from the intersubjective field so that space is available for the creation of shared meaning. Lysaker and Daroyanni contend that relatedness is co-created in the process of constructing shared meanings, rather than in the fusion of therapist and patient...Relatedness in sessions also did not come about because the

therapist operated as a benevolent figure, but rather from the patient's discovered ability to articulate his experience.... the relatedness comes as the patient shares the therapist's perceptions, perhaps this discovered ability was not a matter of sharing consensually valid perceptions of particulars but of the sharing capacity ties to focus, recall, and connect previously meaningless ideas, allowing experience to be meaningfully ordered in an intersubjective space (p. 63-4).

Concluding Thoughts

In this chapter I have attempted to outline some general trends in psychodynamic approaches to the treatment of psychosis. As should be clear by now, the theoretical frameworks of individual practitioners do not conform neatly into the traditions with which they are associated. For example, Lysaker aligns himself with intersubjectivity, yet with regard to honoring the clients' subjective experience of his point of view (first versus third) his practice directly contradicts the recommendations of Atwood, Stolorow & Orange (2002). Interpersonal, intersubjective, relational, dialogic theory and phenomenological psychiatry continue to evolve, to borrow from and to depart from one another, and to influence practitioners in often paradoxical ways, exhibiting the postmodern sensibility that there is no one universal explanatory theory or methodology. With this matrix of psychodynamic and phenomenological theory held in mind, and with the values of transparency and nonhierarchical decision-making espoused by the Hearing Voices Movement, the following chapter will examine Open Dialogue's theoretical underpinnings, system of service delivery and long-term outcomes for first-break psychosis.

CHAPTER 6

Open Dialogue

This chapter discusses the recent innovation of Open Dialogue, which is a two-pronged approach to addressing psychiatric crises, pioneered within the last thirty years at Keropudas Hospital in the Western Lapland region of Finland by Jaakko Seikkula, Jukka Aaltonen, Birgitta Alakare, Jrki Keränen, and Kauko Haarangas (Seikkula & Olson, 2003). These individuals were influenced by the work of Gregory Bateson and the Milan School's family systems theory; Russian literary theorist Mikhail Bakhtin's conceptions of dialogic communication and identity; Finnish psychiatrist Yrjö Alanen's need-adapted treatment; and Norwegian psychiatrist, Tom Anderson's reflecting teams (Seikkula & Olson).

In accordance with dialogic principles, "Prior states constrain but do not necessarily determine outcomes" (Morson & Emerson, 1990, p. 47). Open Dialogue's emphasis on engaging the social network of the person at the center of concern is one of several differences between its actualization of dialogic practice and that of the individually-based psychotherapeutic work of Lysaker and Stanghellini, which was discussed in Chapter Five. Open Dialogue takes as its premise the idea that a better outcome can arise when there is a more nuanced understanding of the situation. This nuanced understanding is facilitated by the participation of the social network. Seikkula & Arnkil (2006) explained:

A psychic crisis or other such worrying situations do not touch the client alone; it also touches the people close to them. In a mutual dialogue, it is possible to reach an understanding that no single party could reach or manage alone. As a result the client's social network becomes a co-creator of the process. When networks meet, shared experience can emerge. Such experience exceeds the capabilities of any single actor (p. 6).

Seikkula and Olson explained that in Open Dialogue “the poetics of the interview are consistent with the micropolitics of the professional environment” (2003, p. 416). Poetics “refers to language and communication practices in face-to-face encounters” (2003, p. 404), whereas micropolitics refers to the organization of the systems of care. These two mutually reinforcing aspects of Open Dialogue further are articulated by the seven principles that are examined later in this chapter: 1) responding immediately, 2) including the social network, 3) adapting flexibly to specific and varying needs, 4) taking responsibility, 5) guaranteeing psychological continuity, 6) tolerating uncertainty, and 7) dialogicity (Seikkula & Olson, 2003; Seikkula & Arnkil, 2006).

History of Open Dialogue

The Finnish province of Western Lapland, where Open Dialogue began, is home to less than 100,000 inhabitants. Western Lapland is to the north of the Gulf of Bothnia and borders Sweden. The majority of the population lives in the southern, industrialized region of the province. Ninety percent of the population is comprised by Finnish-speaking Lutheran Finns who live within 60 kilometers of Keropudas Psychiatric Hospital. In the mid-1980s there was an annual average of 35 new cases of schizophrenia diagnosed per 100,000 inhabitants in this area (Aaltonen et al., 1997).

In the early 1980s, prior to the innovation of Open Dialogue, Milan Systemic Family Therapy was the primary treatment offered by the inpatient team at Keropudas Psychiatric Hospital in Tornio, Finland. In this approach, the treatment team discussed the case and agreed on the treatment behind closed doors, and made a referral to family therapy only when it was indicated (Seikkula & Arnkil, 2006). The team found it difficult to connect with families, and many families did not follow through when referred to family therapy (Seikkula & Olson, 2003). Taking a cue from Yrjö Alanen's Need Adapted Treatment practiced at Turku University Hospital, in 1984 the Keropudas team took the step of inviting families and patients to participate in initial treatment planning meetings, including the family and the patient in the treatment planning process from the onset in every case (Seikkula & Arnkil, 2006). Seikkula writes,

The revolutionary aspects of the Need-Adapted approach were to focus on: (1) rapid early intervention in every case; (2) treatment planning to meet the changing and case specific needs of each patient and family by integrating different therapeutic methods in a single treatment process; (3) having a therapeutic attitude as the basic orientation for each staff member in both examination and treatment; (4) seeing treatment as a continuous process; and (5) constantly monitoring treatment progress and outcomes (2011, p. 181).

The emphasis on facilitating a collaborative and transparent treatment planning process (Seikkula & Arnkil, 2006) is where one can first begin to see the two-pronged nature of Open Dialogue's poetics and micropolitics. Here the experience of the treatment planning is itself therapeutic, or part of the treatment. As opposed to the approach of the Milan School where the family was viewed as an object of the intervention, in 1984, the team at Keropudas began to

involve the social network as a crucial partner in the therapeutic process (Seikkula & Olson, 2003) — where we might hear the echo of c/s/x echo of ‘nothing about me without me!’

While systemic family therapy seemed not to be the solution, we were ‘forced’ to look for other options. Systemic family therapy focused on seeing the problem or symptoms as a function of the family system. But in generating open dialogue we aimed at having all the different voices being heard, without any idea whether they had a function in the family system. Thus the intervention was not to initiate change in family interaction, but to generate new words and narrate new happenings (Seikkula, 2011, p. 5).

These open meetings gradually became the therapy itself, and the concept of dialogism as developed by Bakhtin, Voloshinov and Vygotsky were employed as a theoretical frame. Anderson was developing his idea of the reflecting team simultaneously. The reflecting team and the Galveston group’s collaborative approach to language systems (Anderson & Goolishian, 1988) were both integrated into the Open Dialogue approach (Seikkula & Olson, 2003).

By 1990, the emphasis on hospital-based treatment had shifted to community-based psychiatric treatment. Regardless of diagnosis, when there was a question of hospital admission, community treatment consisted of: 1) organizing a network meeting to decide whether there should be voluntary admission, or holding a network meeting on the first day of compulsory admission; 2) comprising the treatment team of both inpatient and outpatient staff (psychiatrist from crisis ward, psychologist from local mental health clinic, nurse from ward); and 3) ensuring that the same team assigned to the patient/family for the duration of treatment in and out of the hospital (Seikkula & Arnkil, 2006).

Conceptualization of Psychosis

Seikkula and his colleagues view psychosis as a crisis of communication in which the individual is unable to find the language or the context in which to express frightening and extreme experiences. The emphasis on communication casts psychosis as an interpsychic rather than an intrapsychic phenomenon, and positions the social network at the center of treatment.

A common observation seems to be that patients experience reaching something that is unseen by the rest of their family. Although a patient's comments may sound incomprehensible in the first meetings, after a while it can be seen that actually the patient was speaking of some real incidents in his/her life. Often these incidents include some terrifying elements and threat that the patient has not been able or possible to express in spoken language before the crisis. Psychotic experiences most often include real incidents, and the patient is bringing forth themes for which he/she has not previously had words... The aim in treatment becomes generating forms for constructing words for those experiences that did not have words or shared language (Seikkula & Arnkil, 2006, p. 53-54).

When psychotic utterances “errupt” during a network meeting, it alerts the team to the possibility that subjects are being discussed that have a relationship to the “experiences that live in the psychotic speech” (p. 134), signaling the team to “pause any other ongoing dialogue and ask more about what the patient has opened up” (p. 147) to make room for the psychotic speech in the meeting. At these moments, the team attempts to engender the social network's curiosity about and acceptance of psychotic speech. In other words, the team works to create a context in which

it becomes possible to talk about those very frightening and odd experiences and thus for the voice to become one among many other voices in the conversation (p. 133).

When the team neglects to respond to psychotic speech with openness and curiosity, incomprehensible issues may be not acknowledged and thus the patient cannot begin to give words to these experiences or be heard (p. 147).

Seven Principles of Open Dialogue

Open Dialogue as practiced in Western Lapland emerged from a number of studies (Altonen et al., 1997; Haarakangas, 1997; Karanen, 1992; Seikkula, 1991, 1994; Seikkula, Alakare, & Aaltonen, 2001b; and Seikkula & Arnkil, 2006). These principles speak to the poetics and micropolitics of dialogic conversation.

Principle #1: responding immediately.

Providing an immediate response to a crisis serves multiple purposes. It builds a sense of trust with the family that serves to reduce anxiety and builds the foundation for toleration of uncertainty necessary in dialogic conversation. It reduces the duration of the untreated period—“the longer the patient has psychotic experiences before the treatment begins, the worse the prognosis” (Seikkula & Arnkil, 2006, p. 153). Responding immediately also enacts Bakhtin’s assertion that “...for a human being, there is nothing more terrible than a lack of response” (1986, p. 127).

Whereas conventional approaches to treatment of psychosis wait for psychotic individuals to “become more coherent” before organizing family meetings, practitioners of Open Dialogue arrange meetings of the social network within 24 hours of first contact. In order to avoid hospitalization, all concerned parties meet during the first few meetings, which is the most

intense period of psychosis. Access to psychotic experience is valued, understood as important to the therapeutic process, and is not to be foreclosed upon. In the first few days of the crisis

it seems possible to speak of things that later are difficult to introduce. In the first days, hallucinations may be handled and reflected upon, but after that they easily fade away, and the opportunity to deal with them may not reappear until after some two or three months of individual therapy... the window for these extreme experiences may only stay open for the first few days (Seikkula & Arnkil, 2006, p. 54).

If the team is able to engender a safe and receptive holding environment through rapid response and

by listening carefully to all the themes the clients speak of, then critical themes may find a space in which they can be handled and the prognosis improves (Seikkula & Arnkil, 2006, p. 54).

Principle #2: including the social network.

The principle of engaging the social network is related to the principles of dialogicity and psychological continuity. As previously noted in this chapter, the theoretical framework of dialogicity suggests that the more nuanced the view, the more possibility for joint understanding to be created among the players. Here psychosis is conceptualized as a lack of language adequate to describe a terrifying experience, and the lack of a social context to hear such an event described. Dialogic conversation offers the person at the center of concern the opportunity to co-“construct a path out of the psychotic world” (Seikkula & Olson, 2003, p. 414). Network meetings generate

a new type of expertise: a co-created understanding that presupposes laymen and professionals coming together. To be viable, the expertise actually requires the clients and their personal networks to be actively involved... (Seikkula & Arnkil, 2006, p. 91).

If the social network of the person at the center of concern participates in this meaning-making process, the patient will have the benefit of lasting psychological continuity that would not occur if only the helping professionals participate in the process. Network meetings are convened with

...the aspiration to embed the helping efforts in the client's *everyday life, as near as possible to his/her everyday circumstances and relationships*, rather than basing them on institutional communities or relations alone...this is not merely a cognitive process but is, instead, an embodied emotional experience...The new understanding is generated in a shared emotional experience, which means that people become connected with each other in a new, active way (Seikkula & Arnkil, 2006, p. 91-2, emphasis in the original).

Alanen outlined three functions of treatment meetings: to gather information about the problem; 2) to create a treatment plan and make treatment decisions based on information gathered; and 3) to engender a therapeutic dialogue (1997).

Involving the social network mobilizes support for the patient and the family, often allowing for the identification of unexpected resources (Seikkula & Arnkil, 2006). Who the social network includes will vary from individual to individual. While family members are viewed to have an important role, friends, employers, coworkers, VocRehab counselors and other service providers also may be useful to include (Seikkula & Arnkil, 2006). The following questions help to organize a network meeting:

- Who knows of the circumstances and has been concerned?

- Who can be helpful and is also willing/able to participate in the initial meeting?
- Who should invite them (family or treatment team)?
- Are there other professionals to invite who have been assisting or involved with the particular circumstances?

When relevant members of the social network are unable to attend the meeting, their voices can be included by asking: “If _____ was here, what would she say? How would you have responded to her? How would she have responded to that?” Meeting participants also can agree during the meeting to call others and let them know what happened (Seikkula & Arnkil, 2006).

Network meetings are typically 90 minutes, and are facilitated by the therapist/s who organized the meeting. Facilitators encourage participants to sit in a circle and begin the meeting with open-ended questions geared towards understanding how the person at the center of concern and his/her family language the problem; themes are not planned in advance. Team members reflect with one another about what they hear as the family listens. Team members attempt to have as many participants as possible speak early in the meeting using their own language about what is of concern to them. In this way the professional team is adapting and responding to the family rather than the other way around. The professional team responds to family by asking further questions to understand better or reflects to the team about what they just heard. In these reflections team members might introduce new words to help the patient language their own unspeakable experiences (Seikkula & Arnkil, 2006). Professionals who have role specific obligations are encouraged to wait until the end of the meeting to discuss these so that the family has the opportunity to set the agenda for the meeting. The facilitator concludes the meeting by asking if there’s anything else that should be discussed before the session ends, summarizes

themes, and reviews what decisions, if any, have been made or require further consideration at a subsequent meeting (Seikkula & Arnkil, 2006).

Defining the problem.

If psychosis is conceptualized as the breakdown of communication in a social network, then the question emerges of where the problem resides. Like the intersubjectivists discussed in Chapter 5, Bakhtin dismisses the notion of discrete psychic entities.

Perhaps we are inclined to metaphors of territory and boundary because we think of individual selves occupying a specific place at a specific time. But although this is true of and necessary for physical bodies, it is untrue of psyches or of any other cultural entities (Morson & Emerson, 1990, p. 51).

Seikkula and Arnkil contend, “there are as many problems as there are actors” (2006, p. 37). Each person involved in the crisis, or “worrying situation” (2006, p. xviii) has their own view and experience of the problem, or each has their own set of problems that inter-relate and affect each other. The particularity of each person’s problems is shaped by their place in the social relations of the family. Everyone who is connected to the issue at hand has a point of view which cannot be selected arbitrarily. The points of view are not interchangeable, but each actor can *diversify* his/her view by learning more about how the perspective opens up from the position of others. The others’ different views offer a contrast, an affordable difference that affords one possibilities to learn more about one’s own point-of-viewness (Seikkula & Arnkil, 2006, p. 39).

Seikkula and Arnkil (2006) go on to argue that there is no objectivity separate from point of view, and that the only “objectivity is understood as intersubjectivity” (p. 39), in which the quest for a birds eye view is replaced by the opportunity for a fuller view afforded by dialogism. Once

“the problem” leaves the realm of Cartesian individual pathology, and becomes multi-perspectival and variously defined, involving the social network is a logical outcome. The point is not to create “unanimous understanding of the problem” (p. 91), but to try to “understand each point of view” (p. 91).

A problem becomes a problem after it has been defined as one in the language of either those nearest the patient or by the patient him/herself...the problem becomes dissolved only if all that have defined it as a problem no longer communicate it as such (p. 54-55).

Bateson’s theory of the double bind has been widely interpreted as a philosophy of blaming the mother for engendering psychosis in the child, this in turn gave rise to a backlash against meaning-making approaches to psychosis (Olson, 2005). The concept of the schizophrenogenic mother was promoted by professionals as the same time as psychiatric hospitals were shut down, and the family members—who were believed to have cause the illness—were now responsible for caring for the chronically mentally ill (Lukens & McFarlane, 2002). Open Dialogue seeks to offset this blame-guilt/cause and effect paradigm by focusing on the present moment of communication in the social network rather than looking for a “cause” of psychosis. Olson writes that Open dialogue and other

newer postmodern therapies strive to reduce blame and guilt and increase the sense of agency, thus paradoxically maximizing the resources and “response-ability” of the patient, family, and helping network (Olson, 2005, p. 138).

Principle #3: adapting flexibly to specific and varying needs.

Open Dialogue is perceived as a way of thinking and acting, and while poetics and micropolitics have been articulated and systematized to support this way of thinking and acting, it cannot be manualized by virtue of its commitment to offering a response to a specific rather

than a generic context— Seikkula and Arnkil (2006) would argue that as there is no generic context there can be no generic treatment imposed for that disregards attention to context. Just as the professional team adapts its language to the language of the person at the center of concern and his/her family, the team meets at the patient's home or at a location agreeable to the patient and his/her family. In so doing, they have found that

home meetings appear to prevent unnecessary hospitalizations, since the family's own resources seem to be more available in a home setting (Seikkula & Arnkil, 2006, p. 56).

Seikkula et al. have found that in the interest of establishing safety, security, trust and psychological continuity as well as reducing anxiety, it is helpful to meet each day during the most acute phase of the crisis, which typically lasts an average of 10-12 days. After the acute phase, in accordance with Alanen's Needs-Adapted Treatment (1997), the family guides the frequency of meetings.

Principle #4: taking responsibility.

Part of taking responsibility is fostering the development of teams that are committed to offering an immediate response (see the first principle, above). The person at the center of concern, a family member or other member of the social network or a professional can be the one to alert the crisis team to the worrying situation. As noted above, the individual taking this call is responsible for organizing the team and the first meeting and all subsequent meetings. The person who takes the call does not refer responsibility to another professional or specialist, but may ask the family if they are willing to have a relevant specialist participate in the meeting. If so, it is the role of the team organizer to invite them.

In the meetings, the decisions are then made as to who will best form the team that will take care of the treatment.... the team mobilized for the first meeting should take all the

responsibility needed for analyzing the current problem and planning the future treatment. All that is needed for a good-enough response is available in the room: there is no other authority elsewhere that will know better what to do (Seikkula & Arnkil, 2006, p. 57-58).

If a significant member of the social or professional network cannot be reached, such as a doctor, they can be contacted during the meeting by phone. If there is a difference of opinion, a joint meeting is organized to ensure that treatment decisions are discussed openly with the patient and the family to afford them a meaningful role in this process (Seikkula & Arnkil, 2006).

The team that co-facilitates the first meeting, is responsible for organizing treatment for the person at the center of concern and for the family, rather than burdening the family with coordinating a complicated constellation of service providers. This also helps to prevent the double bind situations that have been found to be typical of acute situations in which multiple providers are involved. In Open Dialogue it is the team's job to integrate the professional's response rather than leaving the client to navigate these conflicting messages, mandates, and priorities "reducing the iatrogenic effects of the patient's involvement with multiple systems" (Olson, 2005, p. 142).

Principle #5: guaranteeing psychological continuity.

The team may meet with the social network for just two meetings, or for a number of years depending on the needs of the person at the center of concern. For 65% of families the need for network meetings attenuated within two years (Seikkula & Alkare & Aaltonen et al., 2003). Because the teams are comprised of professionals across institutional boundaries (inpatient, outpatient, VocRehab etc.), psychological continuity is maintained in all phases of treatment. Similarly, the members of the patient's social network are encouraged to participate in

both planning meetings and therapeutic meetings (Seikkula & Arnkil, 2006). Open Dialogue seeks to integrate varying methods rather than have them compete with each other. For example, if individual therapy is indicated during a group meeting, one of the team members may provide this, or the individual therapist may be invited to visit the meetings on occasion.

The treatment community is based on guaranteeing continuity and psychological security and is different compared to traditional psychiatric care. It is not an artificial community in the ward, but a network of real living persons who are important in the patient's life (Seikkula & Arnkil, 2006, p. 112).

Principle #6: tolerating uncertainty.

The first priority of professionals is assessing and increasing safety. The second priority is to mobilize psychological resources of the patient and their social network to increase their sense of agency.

This means creating stories about their most extreme experiences. This is strengthened by building up a sense of trust in the joint process (Seikkula & Arnkil, 2006, p. 59) and tolerating the uncertainty and ambiguity inherent in a joint and participatory meaning-making process. Meeting daily for 10-12 days bolsters the sense of safety and trust in the process. Once this sense of security has been generated for the family, it is possible to reduce the frequency of meetings based on the guidance of the patient and family. Treatment decisions are held off during the crisis phase including decisions about neuroleptics. Options are discussed but not decided upon.

When deciding about the use of neuroleptics, the team encourages the network to discuss this possibility for at least three meetings before beginning a regime of medication. Neuroleptics are approached with caution as they can diminish psychological resources at the same time as

removing symptoms and their sedative effects can inhibit psychological processing. Team members are tasked with the challenge of creating “a process that at the same time, increases safety and encourages personal work” (Seikkula & Arnkil, 2006, p. 60). Safety is defined as: 1) supporting family and not leaving them alone with problems or perceived physical danger; and 2) engendering a quality of discussion in which all voices are heard and responded to. Professionals can take responsibility for listening to, responding to and tracking different members of the family.

Already in the very first meeting, it is good to spare some time for reflective discussion among the team from these different or even contradictory perspectives. If the team members can listen to each other, it may increase the possibilities for the family members to listen to each other, as well (Seikkula & Arnkil, 2006, p. 60).

The team encourages the network to avoid rapid decision-making, which alleviates any sense of pressure to come to a decision in order to conclude that day’s meeting. Instead, the facilitator summarizes what has been discussed and what questions remain open and suggest these be discussed further at the next meeting. To assist the network in tolerating this uncertainty, facilitators conclude the meeting by making sure family members know what to do if they need help prior to the next meeting.

As part of this approach the question that a crisis poses, ‘What shall we do?’ is kept open until the collective dialogue itself produces a response or dissolves the need for action (Seikkula & Olson, 2003, p. 408).

During the meetings, the team seeks to increase the family’s capacity to tolerate ambiguity by: 1) encouraging network members to share their stories in detail, then asking for others to comment on those stories to “generating a multi-voiced picture of the incident”

(Seikkula & Arnkil, 2006, p. 118); 2) normalizing psychotic speech by welcoming it into the conversation thereby validating “extreme life situations that engender psychotic ideas and feelings of hopelessness” (p. 118); 3) shifting from interviewing clients to reflecting with their team to model “wondering together,” (p. 118) offering the clients the space to wonder internally as professionals wonder aloud; and 4) working slowly to create space for emotions to be felt together so that processing occurs implicitly as well as explicitly. The team encourages the family to stay in the present moment of current interactions and in so doing demonstrates how to weather difficult emotions. Finding a language for these emotions is key:

...for the words to be found, the feelings have to be endured...experiences that had been stored in the body’s memory as symptoms are ‘vaporized’ into words (p. 119).

Usually the family has been subject to the same traumatic events as the person at the center of concern. Network meetings become a time for all concerned to collectively process emotions connected to these events.

By tolerating this uncertainty, network members discover in their sharing of the situation the psychological resources to bring to the question of how to move on (p. 118).

Principle #7: dialogicity.

Open Dialogue prioritizes: 1) promoting dialogue; and 2) promoting change in the person at the center of concern and their family. Dialogue is understood as a way to increase the agency of the person at the center of concern and his/her family by discussing problems:

...a new understanding presupposes a dialogical conversation. New means are generated in the area between those participating in the discussion (Seikkula & Arnkil, 2006, p. 61).

In a dialogic conversation, all participants act as the thinking subject, whereas in a

monologic conversation, the person at the top of the social hierarchy—in conventional mental health treatment this is most often the psychiatrist—has the power to define reality. In dialogical relations all of the voices participate in the joint construction of new meaning. The utterance is considered to be a social act. What is said is influenced by the social context and social relations.

In treatment or help situations, all this highlights the importance of how we construct the situation for the dialogue... if we start to speak in a way that considers all the people present, we can encourage the network members toward a more active stand in the conversation, which again forms the direction of the conversation in the meeting.

Individuals participating actively in the conversation more readily become part of each one's inner structure rather than sitting as passive onlookers in the room (Seikkula & Arnkil, 2006, p. 99).

In a dialogic frame, the utterance is understood as distinct from the sentence. A sentence can be repeated, however, an utterance is more than the sentence, it is the meaning of the sentence that varies with each particular context (Morson & Emerson, 1990).

Because context is always changing, every conversation has new healing potential. As soon as someone speaks, the listener has an embodied response that in turn affects the speaker and what is said:

In a conversation with clients we can affect the situation by our responses. We have an essential impact on what type of space is left for the clients and how their responses can affect the joint forthcoming process of dialogue (Seikkula & Arnkil, 2006, p.102).

In monological relations, a conversation ends based on who has the power to decide the answer whereas in

a dialogical utterance does not wait for an approving or rejecting answer, but, rather, for a reply that opens up new perspectives to what is said (Seikkula & Arnkil, 2006, p. 103).

For someone to be answered, they must first have been heard. This process of hearing each other creates a “feeling of togetherness” even when the togetherness is forged by sitting with the hopelessness of a crisis situation. Bakhtin conceptualized dialogue as rooted in the body, “bodily dialogue between subjects in space and time” (Seikkula & Arnkil, 2006, p. 97). In network meetings, professionals aspire to sit as whole people, and to allow themselves to be affected by the emotions of this embodied experience with the social network. The professionals are both moved by the experiences in the room and are less vulnerable to them as they are not as involved in the history of the family. In this way, they are able to lend the social network

a secure framework in which network members discuss their abilities to sustain conversations about the most difficult of experiences...their experiences with other crises in other networks have shown them that the current crisis can be survived. The particular experience of the team members is embodied in their presences in the room, as they radiate calm confidence and compassionate engagement. Demonstrating with their embodied presence that it is possible to talk-through extremely difficult experiences, they afford feelings of safety that make it possible for network members to venture forth from their monological impasse (Seikkula & Arnkil, 2006, p. 109).

In this process, rather than viewing the person at the center of concern or the family as the object of intervention, the professionals are co-participants in the “mutual process of uttering and responding” (Seikkula & Arnkil, 2006, p. 109). Their role is to emphasize the process of generating dialogue through which the clients have access to more possibilities for communicating about their extreme experiences, experiences that are currently manifesting as

symptoms. In contrast with family systems therapy, there is no structure or family logic or set of rules to be changed, the family reinvents itself in each new conversation (Seikkula & Olson, 2003).

Polyphony.

The process of participating in dialogic conversation is enabled by one's ability to experience the polyphonic self. Seikkula & Arnkil (2006) described this polyphonic sense of existence as

living in a multiplicity of voices that will be turned on and playing simultaneously according to *what, where, how, and with whom we are talking*...each person's social meaning and social identity is created in the actual conversation instead of thinking that they would stay the same from one social situation to another (p. 99).

Voices include what is spoken aloud, what is unspoken, as well as nonverbal communication. With the aim of joint understanding, Open Dialogue's incorporation of the reflecting team, developed by Tom Anderson, enables professionals to separate out the process of speaking and listening. This serves to encourage meeting participants to have space to consider their own inner dialogues. In the reflection process, members of the professional team articulate their differing perspectives and speculations about the situation. In so doing, they both model how to tolerate a multi-perspectival understanding of the issue, and create space for choices and alternatives rather than imposition of a set treatment plan onto the family and/or patient of concern. This is particularly important when decisions about hospitalization, medication, discharge or treatment are made, so that clients are aware of, and have a say in their choices (Seikkula & Arnkil, 2006).

To engender polyphony professionals encourages all members of the social network to speak as early as possible in the meeting about their view of the problem. Rephrasing what a

participant shares as a clarifying question provides participants the opportunity: 1) to consider their own words, and affirm or elaborate or amend those words; and 2) create joint understanding. Inquiry into psychotic experience and statements models the inclusion of psychotic experience into the range of voices accepted in the conversation. Rather than orienting those who express psychotic experience to “reality” the team can respond with

‘I have not experienced something like that. Could you tell more about them so I can understand more of your experiences’ (Seikkula & Arnkil, 2006, p 64).

Professions may find it helpful to shift to reflective conversations when clients are recalling the most frightening aspects of their experience and “in danger of becoming disorganized” (Seikkula & Olson, 2003, p.413). This offers the social network a way of understanding extreme or difficult behavior as making sense within a specific context. For example, if the person at the center of concern was recounting an event leading up to the psychotic experience, the professional might ask how the person felt at the moment of experiencing the frightening event, or the moment afterwards, and might offer language to describe the experience.

the focus here is not on creating an intervention but on creating a language for the [family’s] experience that reconstitutes the voice and agency. The themes developed by the team borrow from—and build on—the words used by [the family] (Seikkula & Olson, 2003, p. 413).

However, in using a different word than the client, the therapist, to be true to dialogic principles, must do so with the intent of

trying to understand; the intent is not to give the client a new word. All utterances are an attempt to understand and not misunderstand (Anderson, 2002, p. 280).

The reflecting team, the social network, and the room for polyphony offers the psychotic client the opportunity to reflect on his own experience providing him with “freedom from captivity” (Seikkula & Olson, 2003, p. 414). If conversation isn’t moving, professionals can use circular or surprising questions and can draw attention to difference in perspective among family members to generate more dialogue. When professionals are able to bring a sense of security, stability, tolerance of ambiguity to the social network, and to increase the range of polyphony in the room, the social network has an increased potential to revitalize its communication processes and sense of connection.

Dialogue is experience. It may lead to living through something that was not possible before... In dialogue the new experiences often emerge as bodily relaxing emotions, and it might be that just this moment of relaxing in the dialogues about the most extreme concerns in one’s life is the turning point towards healing and problem solving.

Symptoms can be seen as a way of living that are settled down in our bodies, and they are difficult to formulate into spoken narratives because of their most anxious content.

Through joint sharing, a new language may emerge. In this new language, stories can be told that were not previously possible because of either the anxiety aroused or the traumatic content of the experiences. Words arrive in the place of symptoms, provided that it is a dialogical meeting. The body can start to function towards dissolving the symptoms after a relaxing of the tensions in the meeting (Seikkula & Arnkil, p. 125-6).

Role of the Therapist

In Open Dialogue, therapists are called upon to adapt themselves to the culture of the family, rather than impose a preconceived notion of what treatment, health or good outcomes

should look like. Seikkula & Arnkil (2006) warn, “There is a danger that the interviewers emphasize questions that fit their hypothesis” (p. 94). In this approach, therapists are not interviewing for the sake of gathering information to make a diagnosis or formulate a treatment plan.

No distinction is made between healthy or sick utterances in Open Dialogues, either, they all are voices in constructing a new joint understanding (p. 94).

This stance challenges systemic family therapy principles and requires flexibility, openness and mutuality in the treatment process. In this approach, therapists take responsibility to change their own behaviors and perspectives when reaching an impasse with the client in hopes that changes initiated among themselves will lead to change within the person at the center of concern and their social networks (Seikkula & Arnkil, 2006). The mutuality and polyphony of this process opens up new viewpoints into the worrying situation allowing for access to unforeseen resources. Therapists are not seen as interchangeable representatives of an institution or program. It is the continuity of particular relationships built over time that provide the scaffolding for reconnection to the self and others. Open Dialogue is successful when to the extent that a partnership between the social network and the professional team is realized:

...the interaction with the family does not become *curative* by the mere fact that a psychiatric treatment team takes part in it. Only if the team can bring structure, flexibility, and a multifaceted problem analysis into the boundary system can it help to make the interaction curative. That this will happen can by no means be taken for granted... The family brings the problem and the culture of its activity to the system of boundary. The treatment team can bring its treatment tasks, its organization, its flexibility, and its versatility. The emphasis was no longer on the general expertise of the

team: the crux was the team's ability to adapt to each situation... if the team can both adapt flexibly to the family's activity mode and bring in organization and versatility, then co-evolution may enhance mutual recovery and mutual learning (Seikkula & Arnkil, 2006, p. 29-30).

Innovators of the Open Dialogue approach emphasize that providers must learn to view mental health service users as "empowered agents with the focus shifting away from (merely) their disabilities" (Seikkula et al., 2011, p. 201). To do so, providers need to deepen their relational skills, increase their capacity to participate in "transdisciplinary team work" (p. 201), and privilege these aspects of the work as much if not more so than their expertise in diagnosing and prescribing pharmaceuticals (Seikkula et al., 2011, p. 201).

Power Relations

Open Dialogue's explicit attendance to power relations is one of its therapeutic virtues. Careful consideration of social relations are deeply integrated into all seven of its principles. That said it never purports to achieve or to aspire to a symmetrical relationship between clients and professionals. Seikkula and Arnkil (2006) are well aware of the ways in which professionals occupy a power position, reminding the reader that there are "no social relations without elements of social control" (p. 43). Professionals are paid to participate in network meetings; and in some cases their involvement is mandatory. Professionals are cast in the role of the "helper" and psychiatric problems are their "home turf" (p. 189). Professionals assume the role of "controlling authorities" (p. 43) as mandated reporters are gatekeepers to public assistance and other valuable social and economic resources.

Rather than attempt to renounce or deny the asymmetry of this power dynamic, Seikkula and Arnkil (2006) pose the question of how to use this power to promote empowerment. Helping or supporting can be used to subjugate or to empower; to engender dependency or independence:

empowering control enhances the other's self-control; however subjugating control narrows down his/her autonomy (p.43).

Network meetings are asymmetrical as professionals are present, however, the role of professionals is to make room for the reflective space that in turn increases the client's agency. As will be discussed later in this chapter, Seikkula (2002) and his colleagues have analyzed the relationship between the balance of power in cases with good outcomes versus cases with poor outcomes and found that the best outcomes were achieved in those cases where the person at the center of concern and their family were able to realize the most agency in the network meetings.

Open Dialogue intersects with power relations at a macro level as well. While its outcomes are promising, it also is threatening as it involves changing the system of how care is delivered, and challenges the prevailing paradigm of professional help (Seikkula & Arnkil, 2006). In the Open Dialogue paradigm professionals ask for help from client and their social network. They focus on changing their own activity rather than on trying to get the family to change. Treatment is a mutual process (professionals, family and person at the center of concern are all involved in the change process). The client's social network is viewed as resource rather than holder of pathology. Neither an objective truth nor unanimity is sought. Instead the point of view of each person is elicited to create joint understanding. The client and social network participate in treatment planning as part of the therapeutic process. Listening is privileged over providing advice as a way to demonstrate expertise. Institutional boundaries are crossed in contrast with the trend of lack of communication between specialists and the tendency towards

siloining. The emphasis on normalizing psychotic experience that can be assuaged through restoring language and communication challenges the prevailing (and Pharma-funded) discourse that explains psychosis as a chemical imbalance or genetic vulnerability. The approach of Open Dialogue is best expressed as an attitudinal shift, the principles of which cannot be reduced to a manualized technique.

Evidence Base

According to a study conducted in 2011, using the Open Dialogue approach, as of 2005 new cases of schizophrenia in Western Lapland decreased from 35 cases per 100,000 individuals to 2 cases per 100,000 individuals (Seikkula et al., 2012). In addition, the DUP (the duration of the untreated period) had declined from two to three years in Finland’s traditional psychiatric system to three weeks in Western Lapland; and 84% of individuals served had returned to full employment. Furthermore, this study had replicated the following results of the period from 1992-1997 in which only 35% were treated with neuroleptics, 81% experienced complete remission of symptoms, and 81% had achieved full employment (Seikkula et al., 2002). Due to the success of Open Dialogue, by 1997, institutionalization of the chronically mentally ill had ceased (Seikkula & Arnkil, 2006). Table 3 shows these figures.

Table 3: Outcomes of the 1994-1997 Open Dialogue Cohort at the Two-Year Follow-Up		
	Open Dialogue	Traditional Psychiatric Treatment
Average length of hospitalization	14 days	117 days
Use of neuroleptics	30%	100%
Relapse rate	30%	71%
Remaining psychotic symptoms	17%	50%
Receiving disability benefits	19%	57%

(Seikkula & Arnkil, 2006)

At the five-year follow-up mark, 82% of patients in the Open Dialogue group had no remaining symptoms and 86% were working in school or seeking employment (Seikkula & Arnkil, 2006).

Furthermore, researchers had found that hospitalization increased the risk of a poor outcome; and postponing the start of neuroleptic medication in an active psychosocial treatment seems to increase the use of the patient's own psychological resources and those nearest her/him. Neuroleptics should be used if needed as a part of active programmes. In cases where the entire treatment can be conducted without neuroleptics and the patient recovers from psychosis the prognosis seems to improve (Seikkula & Arnkil, 2006, p 162).

In a 2011 study, Seikkula, Alkare and Aaltonen compared outcomes for three cohorts of patients presenting with 1st episode psychosis who had received services in Western Lapland, where Open Dialogue is the basis for the psychiatric system. The three cohorts included: 1) the API period from 1992-1993; 2) the ODAP period from 1994-1997; and 3) the second ODAP period from 2003-2005. Across all cohorts, at the two-year follow-up mark, more than 70% of patients had not relapsed and 80% reported no remaining psychotic symptoms. In the second two cohorts 14%-16% were receiving disability benefits and more than 84% were

studying, employed or actively seeking employment. This result has stayed the same over a 10-year period involving different individual patients (Seikkula et al., 2011, p. 201).

The researchers attribute the dramatic decrease in the period of untreated psychosis to the extent to which the approach of Open Dialogue has transformed the region's culture of utilizing psychiatric services through involvement of social networks and the offering of comprehensive training in individual and family therapy that is provided for all mental health service providers.

This training has

made the treatment system itself more willing to consider psychotic phenomena from a

psychological and systemic viewpoint: the entire treatment system is more oriented towards the changing needs of patients, families, and their relational systems... (Seikkula et al., 2011, p. 201).

Every year, Western Lapland's community psychiatric system treats an average of 1,500 patients. In almost all cases close members of the immediate family participate in the treatment, amounting to 4,500-7,000 family members per year—10% of the region's population (Seikkula et al., 2011). The impact of reducing the period of untreated psychosis is that psychotic symptoms are less entrenched at the time of contact with the treatment system, further promoting better outcomes (Aaltonen et al, 2011). Relatedly, researchers attribute the decline of new cases of schizophrenia in Western Lapland to the merits of Open Dialogue's need-adapted approach.

Continuous efforts have been made over several years to develop the culture according to the principles of the need-adapted approach, with open dialogue as an important constituent. It appears that the open dialogue, with its early engagement with mental health problems, and retention of family involvement and the social network, plays an important role in the prevention of further deterioration into schizophrenia (Seikkula et al., 2011, p. 201).

Impact of dialogicity in network meetings.

In 2002, Seikkula conducted a study comparing the initial meeting transcripts between cases with good and poor outcomes. The study examined three categories of dominance: 1) quantitative, who spoke most of the time; 2) semantic, who introduced new themes or words; and 3) interactional, who had control over the majority of "communicative actions, initiatives and responses" (p. 141). In addition, the study analyzed the relative proportion of indicative (factual referents) versus symbolic (words referring to other words or ideas) dialogue; and the proportion

of monological dialogue, speech that is not adapted as a response to others versus dialogical dialogue, utterances that respond to previous communication and seek a response. Based on his findings, Seikkula (2006) reflects:

When a family had the possibility to become involved in a symbolic-language area, dialogue persisted longer around a specific theme, whereas in the case of indicative language, the team often asked questions one after another and the conversation itself remained in a question-response form (p. 142).

Table 4 shows the outcomes of family engaged network meetings.

Table 4: Analysis of network meetings in cases with good and poor outcomes		
	Good Outcomes	Poor Outcomes
Interactional dominance of clients	55-57%	10-35%
Semantic dominance of clients	70%	40-70%
Quantitative dominance of clients	No difference	No difference
Proportion of symbolic language	38-75%	0-20%
Proportion of dialogic communication	60-65%	0-50%

(Seikkula, 2002; Seikkula & Arnkil, 2006)

Concluding Thoughts

Seikkula and his team of mental health workers have developed a self-reflexive and integrative model of approaching mental health crises whose outcomes challenge the prevailing discourse of schizophrenia in the western world. They have shown that schizophrenia is not an incurable degenerative disease, and that it can be eradicated with a system of care that emphasizes psychosocial rather than neuroleptic treatment. Rather than opting for short-term savings, it provides individuals and families with intensive relational treatment during the acute

phase of the illness that in turn promotes long-term self-sufficiency, in stark contrast to the high rates of long-term disability in the United States (Whitaker, 2010).

Principles of this organization have been embedded in the entire state social and health-care network in the province. In fact, the same concept is also applied in situations other than psychiatric and social crises—for example, in organizing debriefing in different types of post-traumatic situations (Seikkula & Arnkil, 2006, p. 52).

The innovators of this approach would caution others against adopting their system wholesale. They argue instead that the Open Dialogue approach needs to be in dialogue with the other contexts for other context-appropriate versions to emerge (Seikkula & Arnkil, 2006).

If therapists and administrators get caught up in duplicating what they might think of as its pragmatic aspects, for instance mobilizing a team and a patient and their support system in the patient's home at the time of psychotic crises and budget cuts it might be impossible. If, conversely, they are convinced of its relevance and effectiveness, its philosophy can be innovatively tailored in a variety of ways yielding possibilities for any clinical setting or any presenting clinical dilemma (Anderson, 2002, p. 281).

In Chapter Seven, the points of overlap and of differences between the three meaning making approaches to psychosis (Hearing Voices Network, interpersonal and intersubjective psychotherapy and Open Dialogue) will be discussed to promote viable and transformative support for individuals experiencing psychosis in the United States.

CHAPTER 7

Discussion

The previous three chapters have outlined c/s/x-based, psychodynamic and social network-based approaches to addressing acute psychosis. This chapter examines the points of overlap and points of disjunction in the way these three approaches conceptualize psychosis, healing and treatment with focus on power dynamics, interpersonal healing, medication, hospitalization, and the course and frequency of treatment. This examination is supported by case material to highlight the concepts discussed in this chapter. I conclude with implications for current practice emphasizing feasibility in the contemporary context of the United States.

Diverging Conceptions of Psychosis: Hallucination and delusion vs. visions, voices and unusual experiences

Chapter Four noted the research of Romme and Escher, which informed that Hearing Voices Network (HVN) suggests that visions, voices and other unusual experiences originally identified as the hallmark of schizophrenic symptoms are actually within the range of normal human experience (Dillon & Longden, 2012), and are not indicative of mental or physical illness (Johnstone, 2012). According to HVN, it is not the visions and voices that are the problem; it is the extent to which a person finds these experiences to be distressing and alienating from self and others (HVN, 2013; Romme et al, 2009).

HVN calls itself a ‘post-psychiatric’ organization that privileges holistic solutions over reductionist illness models and positions itself outside statutory services in recognition of its view that voices are more appropriately understood as a human variation, like sexuality, rather than a symptom of a mental disease (Dillon & Longden, 2012, p. 130-131).

The Network seeks to both offer individuals a supportive community to share their own perspectives about their experiences and to dismantle one conception of psychosis, schizophrenia or reality, while at the same time offering personal experience-based assistance to those who seek to explore connections between their present experiences and past trauma (Dillon & Longden, 2012; Hornstein, 2009). The Network draws a clear distinction between self-help groups and treatment groups, defining itself as the former rather than the latter (HVN, 2013). Sullivan took a non-pathologizing view of schizophrenia in the text entitled *Schizophrenia as a Human Process* (1962), and rather than conceiving of it intra-psychically in accordance with classical psychoanalytic principles, he posited that schizophrenia proper (Evans, 1996) had its roots in interpersonal processes. In other words, for Sullivan, while all humans experience some degree of schizophrenic processes, there is a point at which such problems in living (as he practiced he favored this term over diagnostic ones) become more extreme. The Network leaves the cause of these problems of living as one to be defined by the individual, while Sullivan views them as resulting from early childhood interpersonal difficulties. Fromm-Reichmann and Karon are aligned with Sullivan’s interpersonal perspective yet continue to use the language of diagnosis and symptoms. While Fromm-Reichmann and Karon view early childhood family dynamics as the locus for interpersonal trauma, Sullivan also calls attention to the impact of peer relations and societal messages. Sullivan’s notion of therapist as participant-observer

acknowledges that for better or for worse, the therapist influences the patient's expression and experience, implying that it is not possible for the therapist to be an objective observer. While this is a departure from the classical analysts, it is still an asymmetrical relationship with the truth as compared to interpersonalists (Sullivan, Fromm-Reichmann and Karon) that presuppose a knowable reality that the patient is too psychologically compromised to accurately perceive.

The phenomenological psychiatrists, intersubjectivists and innovators of Open Dialogue claim to eschew etiological debates about the causes of schizophrenia, and are instead primarily concerned with the endeavor of attempting to understand the subjective experience of the individual at the center of concern. They vary in their use of diagnostic and pathologizing terminology but use the diagnostic category of schizophrenia. Those who are influenced by dialogic theory conceive psychosis as a disturbance of polyphony (Lysaker & Lysaker, 2011; Seikkula & Arnkil, 2006; Seikkula, 2011; Seikkula & Olson, 2003). While Lysaker explores this in individual therapy with the aim of restoring a harmonic inner polyphony, Seikkula conceptualizes psychosis as a failure of communication within the social network, where psychotic symptoms express what language cannot (Seikkula & Arnkil, 2006). Seikkula and his colleagues seek to abide by no absolute truth, and to forge joint understanding of a multi-perspectival reality (2006), and to make room for the psychotic voices in the social network. The following passage offers an opportunity to explore how notions of sane versus psychotic continue to inform Open Dialogue.

The psychologist asked if Pekka thought that those things were coincidences, and he answered that he now thought that they were. The team agreed that if Pekka now thought that there were no magical powers affecting his relationship with his former employer,

then he was no longer psychotic. In this shift, he seemed to show a new sense of personal agency, in contrast to being controlled by a destiny (Seikkula & Olson, 2003, p. 414).

This passage raises the question whether practitioners of Open Dialogue would agree that magical powers are psychotic. Authors here are concerned with the extent of agency Pekka experiences in his life, and his increased agency is seen as a result of his concession of magic in favor of coincidence. Hence, is the implication that it is insane to believe in constraints over individual free will? Interestingly, this is in contrast with McGruder's research in Zanzibar that indicated individuals embedded in a social network with a faith-based explanation of mental illness were more likely to see a remission of symptoms, as they were not pathologized and "othered" by their families, rather, their families viewed illness as a blessing sent by God, offering them the chance to be of service and to dedicate this service to God (McGruder, 2004; Watters, 2010).

Over the past year, I had the opportunity to participate in network meetings that were influenced by some of the principles of the Open Dialogue model. Tikka (the person at the center of concern) and her family were Nepali refugees from Bhutan. Tikka was involuntarily hospitalized during the course of these meetings. Several weeks after Tikka was discharged from the hospital, she met with the outpatient psychiatrist (who did not participate in any of the network meetings). When speaking with the psychiatrist, Tikka referenced karma as an explanation for the bad things that were happening to her and shared that she believed there was a curse on her apartment. The outpatient psychiatrist responded by suggesting that she be hospitalized. Later that day, when I was in a meeting with the native-born executive director of a local nonprofit, she too made a reference to the role of karma in her life. Karma is a concept that pervades United States culture, let alone the dominant Buddhist culture of Bhutan and the

Hinduism practiced by Tikka and her family. While Open Dialogue seeks to assist individuals and families with finding the language and developing the capacity to tolerate communication of extreme experiences, it is in no way immune to the assumptions and habits of thinking by those who practice it. In this sense, one might say that the principles of Open Dialogue are a set of aspirations rather than rules.

Conceptualization of the Healing Process

Relational healing.

The Healing Voices Network (HVN) offers individual voice-hearers support through face-to-face groups, literature, a warm line, an interactive website and listserv as well as links to Intervoice, the international movement of voice-hearers (HVN, 2013). Their c/s/x base has a clear sense of the iatrogenic effects of psychiatric diagnoses, one of which is social isolation. The Network and affiliated advocates (Dillon, Romme & Escher) also have pointed out that because experiences of voice hearing are stigmatized and pathologized in our society, the fear around having such experiences, and of the reactions of others towards one's voice-hearing, increases mental distress. The Network's non-pathologizing support group model fosters relational healing by providing a sense of community for those experiencing the iatrogenic effects of psychiatric treatment, social stigma, fear of their own voice hearing experiences and the opportunity to offer support to others based on one's own lived experience (Hornstein, 2009).

Sullivan also stressed the role of the milieu in addressing psychosis, but from a somewhat different vantage point. Sullivan believed that the stigma and shame associated with socioeconomic difference in the United States increased adolescents' vulnerability to psychotic breakdown (Perry, 1962). In his work at Sheppard-Pratt, Sullivan attempted to provide young

men with a corrective emotional experience of a peer group in which they felt accepted and had the opportunity to give and receive compassion. In individual psychotherapy, the interpersonalists (Sullivan, Fromm-Reichmann and Karon) embraced the importance of the corrective emotional experience in which the patient was listened to deeply and the clinical hour offered the patient the opportunity to have a healing interpersonal exchange in the here and now. One key element of relationship is the quality of trust and safety. It is notable that the interpersonalists met with patients daily during the acute phase of the psychosis, which also is true of Open Dialogue. In both approaches, it is the constancy of the relationship, rather than medication that is utilized to ensure safety and security necessary to reduce anxiety and embark on a meaning-making endeavor.

The intersubjectivists (Stolorow & Atwood, 1992), interpersonalists (Hornstein, 2000; Karon, 2003; Evans, 1996) and practitioners of Open Dialogue (Seikkula & Arnkil, 2006) emphasize the importance of the therapist being willing to take an experience-near stance, and to access their own existential terror and isolation—to be moved and transformed by the relationship—in order to be a successful catalyst for healing. The phenomenologists, Lysaker included, caution against the notion of empathy, preferring the notion of sympathy instead, signaling a stance that emphasizes the limits of one's ability to know another, and suggesting that to take an experience-near stance runs the risk of being presumptive (Nelson & Sass, 2009; Lysaker & Dayoanni, 2006). They also contest that experience of psychosis is by definition one of terror, and rather than focusing on drawing connections between past experiences of trauma and present experiences of emotional distress, their focus is on restoring a first-person experience with the self (Rulf, 2003) and interrelatedness with others through the vehicle of the here and now relationship with the therapist (Lysaker & Lysaker, 2011; Lysaker & Daroyanni, 2006)

where the self is defined by its inter-relatedness or intersubjective relatedness (Bradfield & Knight, 2008).

Power and transparency.

The very act of discriminating between psychotic and “normal” thinking, speech and action invokes a power relationship. As discussed at length in Chapter Two, the capacity to define reality and to impose this version of the truth as the only legitimate one is by definition a position of privilege that invokes and perpetuates an asymmetrical constellation of power. We explored the ways in which HVN, interpersonal and intersubjective clinicians and social network approaches concede or share this power to varying degrees. In fact, power relations may be at the heart of psychotic process. Romme (2009; 2012), Dillon (2013), Whitfield (2004), Seikkula (2006), Sullivan (Evans, 1996), Fromm-Reichmann (2000), Karon (2003) and others have pointed to the high correlation between psychosis and traumatic history. If one’s psychic and/or bodily integrity is profoundly compromised by traumatic experiences, and expressed through psychotic experience, it follows that the ways in which dynamics of power are “handled” in the treatment can have both healing and destructive potential.

In the context of Open Dialogue, Seikkula & Olson (2003) have made a useful distinction between poetics and micropolitics in which the poetics refers to the way the network meeting itself is conducted and the dialogic communication it is meant to foster, and the micropolitics refers to how the overall system of care is organized to support those poetics.

Micropolitics and power relations.

Both Open Dialogue and the Hearing Voices Network highlight the importance of increasing the symmetry in the system of care but with different degrees of emphasis. In the context of HVN, expertise of other voice hearers is privileged over that of helping professionals

who are without lived experience, and while many members may choose to work with mental health professionals, this is not seen as necessary to recovery for all members (Dillon & Longden, 2012). Non-professional voice-hearers are seen as capable of supporting each other in the recovery process, both in divining the meaning of the voices and in coping with them (Dillon & Longden). Groups are for the most part, user-led, and are organized on the basis of shared experiences rather than on the basis of shared diagnostic categories. Personal insight privileged over medical knowledge, and HVN's values and structure offers members the opportunity to care for each other rather than to be disempowered as the passive recipient of care which reinforces agency and bolsters members' courage to face the challenges of recovery and the difficulties of self-knowledge and of facing traumatic experiences of the past (Dillon & Longden, 2012).

Through HVN, voice-hearers train mental health professionals and raise awareness locally, nationally and internationally. The decision-making bodies at the national level of HVN and at the international level of Intervoice are largely comprised of individuals with lived experience of voice-hearing. As noted in Chapter Four, to enjoy full membership in the Hearing Voices Network, groups must employ a collective decision-making process; facilitators must not be mandated to report to anyone outside of the group, limits of confidentiality must be decided collectively and the group must aim to be user-led (HVN, 2013). In 2009, HVN conducted a National Consultation report based on focus groups, and responses to postal and web-based questionnaires from 252 individuals, the majority of whom were voice hearers. Both internal and external stakeholders were consulted and the results may be downloaded from their website. Its aims were to: 1) assess HVN's achievements; 2) "Revisit HVN's aims and objectives" and 3) revision HVN to enable it to become a sustainable and more effective organization (HVN, 2009, p.

2). Of the 15 questions posed to respondents, 1/3 requested feedback regarding the leadership and membership structure and power relations within HVN. Other questions attended to mission, goals and objectives and the extent to which they ought to be modified and were being realized.

Of the interpersonal and intersubjective practitioners discussed in Chapter Five, Sullivan's work at Sheppard Pratt is most explicit in attending to the micropolitics of the care system. His decision to create a unit for young men experiencing psychosis free of most of the hierarchy of the rest of the hospital to prevent the iatrogenic effects of institutional coercion was expanded upon by Mosher in the creation of Soteria House in the 1970s. This model includes collective decision-making whereby the only rules that need to be abided by aside from those agreed on by the residents and staff are the laws of the country and what has been specified by the lease and licensing requirements (Mosher & Hendrix, 2004). Alcohol use is permitted unless the residents collectively decide otherwise. There is no curfew.

At Chestnut Lodge, Fromm-Reichmann required all staff (including nurses) to be in analysis, which leveled the playing field between the "sick" and the "experts" to some extent, but as opposed to Sullivan who sought to engender a non-hierarchical culture, Fromm-Reichmann felt that hierarchy was part and parcel of offering patients a secure holding environment in which they could regress in the service of their treatment without being a threat to themselves or others—this included physical restraints (Hornstein, 2000). Patients also were asked for feedback about their experiences at the Lodge, and this feedback was taken seriously, resulting in numerous institutional changes (Hornstein, 2000). When looking at power dynamics it is important to note that treatment at Chestnut Lodge was available only to those who could afford it and further restricted to those who were identified as white. Similarly, Sullivan's ward at Sheppard Pratt was only open to young white men, and the Soteria model targets young adults

experiencing their 1st or 2nd psychotic break. In Mosher's time, the exception to this was in cases where families could pay for treatment out of pocket. In the writings reviewed for this research, neither Karon nor Lysaker elaborate on the iatrogenic effects of the asymmetrical nature of the treatment system or potential ways to offset it. This may have to do with how their conception of psychosis and their poetics de-emphasizes power relations in comparison to the interpersonalists and is discussed in the next section.

In contrast, Open Dialogue is by definition intentional about reducing the iatrogenic effects of institutional practices, and its inception might be traced to the moment when its innovators decided to no longer make decisions about patients without their presence in the room (Olson, 2013). Its innovators do not aspire to a symmetrical power relationship, but to increase the extent to which the person at the center of concern and their social network are empowered within the treatment system. The immediacy of the team's response, the team's inclusion of the social network in decision-making, the privileging of multiple viewpoints, meeting on the family's home turf rather than in the institutional setting reduce reliance on pharmaceutical interventions; and the privileging of community-based treatment over hospital-based treatment influence the balance of power, and increase the agency of the nonprofessional. However, it is also important to note that as Open Dialogue is practiced in Western Lapland, a family meeting is always convened in response to the first call. The meeting can be convened in response to a call made by the person at the center of concern, a family member, a coworker or another helping professional, whereby the question is raised, what if the person at the center of concern doesn't want family or coworkers or other professionals involved?

In the case of Tikka and her family, I learned of Tikka's situation through her mother, Sumitra. She attended a focus group for Nepali-Bhutanese refugees held at a local community

organization and shared her wish for support for her daughter who was experiencing emotional difficulties. Sumitra reported that Tikka was crying and sleeping all of the time, unable to care for her four young children, hearing voices and behaving in other socially inappropriate ways. I invited her to bring her daughter to the mental health clinic where I had my field placement. The leadership of my clinic was reluctant to work with clients that demonstrated psychotic features, and so I called a local agency that was beginning to implement some of the principles of Open Dialogue. I was told to encourage family members and anyone who was a significant part of Tikka's social network to participate in the meeting. It took us five months (meeting 3-4 times per month) to ascertain that Tikka's husband, a regular participant in the meetings, was actively physically abusing Tikka and her children, and she had at times faced recrimination for what she had verbalized during the network meetings. Thus, how can providers both include the social network as part of the treatment team while remaining sensitive to the ways in which this may exacerbate and perpetuate systems of domination already present in the family system?

Poetics and power relations.

Both Sullivan (Evans, 1996) and HVN acknowledge and allow space for discussion of the relationship between the collective trauma induced by societal power relations (such as racism, homophobia, xenophobia and sexism) and distressing unusual experiences (such as voice hearing, visions and unusual beliefs) (May, 2012). Both Fromm-Reichmann and Karon place great emphasis on the self-reflexivity of the therapist, on tolerating uncertainty (Karon, 2003) rather than blaming the patient for being mystifying, and viewing the patient as having a better understanding of themselves than does the clinician (Hornstein, 2000). With varying emphases and to different degrees, Open Dialogue, the interpersonalists (Fromm-Reichmann especially),

the phenomenologists/intersubjectivists and the HVN conceptualize the person at the center of concern as “a knower” and a crucial participant in the meaning-making endeavor.

The social network meetings of Open Dialogue and HVN meetings share the common goal of creating a space in which multiple subjectivities may be articulated, witnessed and better understood, wherein one subjectivity privileged over others’ as the objective truth. In families where psychotic speech is dismissed, facilitators of social network meetings seek to balance out the power dynamic so that psychotic speech is accepted and engaged in a way that does not privilege any one version of reality. As mentioned, all treatment decisions are made in the presence of the person at the center of concern; decisions concerning medication and hospitalization are discussed for at least three meetings before reaching a conclusion; professionals express differing views openly and respectfully rather than the professionals acting as a united front attempting to win the person at the center of concern or the family over to their pre-determined agenda. As noted above, in Seikkula’s case material, Pekka was deemed to no longer be psychotic by his team when he ceased to believe in magic in that his agency was no longer constrained by a belief system that rendered the actions of his employer both beyond his control and logical comprehension (2003). This points to the relevance of intrapsychic as well as interpsychic power relations. The poetics of individual (Lysaker & Daroyanni, 2006; Lysaker & Lysaker, 2011) and social network dialogically based therapy meetings (Seikkula & Arnkil, 2006) are structured in such a way as to attend to intra-psychic as well as interpsychic relations, with particular attention to communication in the here and now relationship. In contrast, the Maastricht approach concerns itself with assisting the voice-hearer to gain control of her voices rather than to be dominated by them, conceptualizing voices as the intrapsychic manifestation of interpsychic and societal power relations with roots in past or ongoing experience outside of the

clinical encounter (Romme, 2012a; Romme & Escher, 2009). Not surprisingly, of all the meaning-making approaches reviewed in Chapters 4 through 7, HVN seems to be the most equalizing in terms of power dynamics in both its poetics and micropolitics. Individual members can discuss their experiences in terms of symptoms and pathology if they wish but there is no presumption of a dichotomy between the “well” and the “sick” in the Network’s language or organizational structure. While the Open Dialogue approach does not aspire to symmetry, acknowledging that so long as professionals are involved, there will be a power hierarchy, they are conscious of the hierarchy and seek to offset its potential iatrogenic effects by increasing transparency and adaptability (Seikkula & Arnkil, 2006).

HVN, Romme, Sullivan, Fromm-Reichmann, Karon and OD make a connection between experiencing psychosis and a history of trauma that has not been able to be integrated or to find expression in conventionally understood speech. This understanding of psychosis evokes relations of power in that the traumatic experience is one of powerlessness in the face of profound psychic and/or bodily threat. The trauma may be relational in the sense that it was 1) “inflicted” in a relational context (by another person), and/or 2) relational in the sense that the experience/s serve to erode the fabric of conventional understanding and assumptions that undergird human connection and communication, engendering a secondary experience of relational trauma. The phenomenologists and intersubjectivists’ may be understood to focus on the latter subjective experience of disconnection, downplaying any historical cause of such a disconnected state of being (Lysaker & Daroyanni, 2006). In this sense, power relations are taken out of the equation, and the therapist is primarily concerned with lending their internal coherence to the patient as the scaffolding for which the patient’s own internal coherence can begin to take shape.

Psychotherapy may serve as a "dialogical prosthesis" to help re-establish the lost connection between bodily feelings (emotions) and interpersonal situations. The task of the therapist is promoting the construction of micro-narratives focused on real world situations (especially here-and-now, You-and-I situations) (Stanghellini & Lysaker, 2007, p. 174).

By defining psychosis solely as a problem of accessing intersubjective engagement (Stanghellini & Lysaker, 2007), there is a danger that the asymmetrical power relations which may have given rise to this rupture in connectedness, are never brought to light, and in that sense, the clinical encounter plays out yet another enactment of the traumatic experience (just as suppression of symptoms via forced medication can be understood to be a silencing and blaming of the victim). The eclipsing of a causal relationship in favor of the focus on the here and now relationship with the therapist is particularly troubling when we remember that the diagnosis of schizophrenia is associated with targets of prejudice and structural discrimination, as well as with low socio-economic status not accounted for by

downward drift..... this suggests and other psychotherapeutic experience makes vivid, the physical and psychological pain, humiliation, and physical danger associated with being very poor in our society—realities which those of us who are not very poor do not like to perceive or to remember (Karon & Widener, 1999, p. 198).

Medication.

Although the psychodynamic, c/s/x and network based approaches to psychosis explored in this research all operate from a meaning-making stance, this does not preclude the use of medication. Sullivan and Fromm-Reichmann were practicing prior to the widespread use of neuroleptics but privileged psychosocial supports over medical interventions (Hornstein, 2000;

Evans, 1996). Karon advocates against the use of neuroleptics feeling that it interfered with the emotional processing necessary to recover, and that when used, clinicians attributed all benefits to medication and none to the psychosocial support (1989b; 2003; 2008). In the case that the clinician's anxiety about working with an un-medicated patient will compromise the clinician's skillfulness, Karon believes it may be expeditious for the patient to take medication (1989b; 2003). In the articles reviewed for this paper, other than to mention that his clients are on medication, Lysaker does not further discuss his position on the topic.

The Network has no absolute stance on medication, aside from the principle that however its members choose to access or to decline treatment is up to them. Romme (Romme et al, 2009) has written extensively about the role of medication in treating psychosis. In his interviews of fifty voice hearers he found that: 1) "medication alone never helped people to recover" (p. 97); 2) psychosocial supports should be promoted as the therapeutic agenda and 3) when used, medication should be in low doses. His stance echoes that of the practitioners of Open Dialogue:

Antipsychotic medication, however, hardly ever achieves a lasting effect on voices. It reduces the person's emotionality, which is useful in the short term but diminishes recovery effects because coping with emotion is not learned (Romme, 2012, p. 161).

Open Dialogue minimizes the use of medication, having found that clients with the least exposure to neuroleptics have better outcomes (2006). Only 30% of clients presenting with psychosis are treated with medication. When medication is used, lower dosages are prescribed than in traditional treatment settings and the standard protocol is that clients will be titrated off of the medication prior to the conclusion of treatment. In some cases anxiolytics are utilized to reduce anxiety, and neuroleptics only are introduced in cases where there has been deeply and

unhurried discussion and after several weeks of psychosocial treatment have not been deemed successful.

The frame: hospitalization, frequency of meetings, intensity of contact.

Both Sullivan and Fromm-Reichmann conceptualize of treatment of acute psychosis in an inpatient setting, with stays, that in some cases, lasted for several years. Fromm-Reichmann lived on hospital grounds and was available to patients daily in both scheduled and unscheduled capacities. Sullivan believed himself to be less central to the treatment of residents on his Sheppard Pratt unit. It was the male attendants he supervised and the milieu setting that made relational healing possible. Karon describes meeting with patients 4-6 days a week during the acute stage, and leaving the office to meet at the patient's home, at a restaurant or at the patient's workplace as dictated by the needs of the particular client (2008). In the articles reviewed for this research, Lysaker describes weekly 50-minute sessions with his patients (Lysaker & Daroyanni, 2006; Lysaker & Lysaker, 2005; Lysaker & Lysaker, 2011). Ability to access HVN meetings, the fellowship associated with these meetings, the warm line and the online community varies from individual to individual. From the literature I surveyed, I saw no recommendations about frequency of participation or connection with HVN members or organized activities. Practitioners of Open Dialogue have found it useful to meet for an average of 10-12 consecutive days during the acute phase of the crisis. They seek to avoid hospitalization to increase continuity of care, to fully access the resources of the social network, and to increase dialogue within the social network. If the family or person at the center of concern is anxious about being a threat to self or others, the team is able to make a nurse available to stay with the client at his or her home to increase the social network's sense of safety. Hospitalization is utilized as a last resort. Frequency of network meetings lessens as the person at the center of concern stabilizes

and gains are made in their recovery (Seikkula, Alakare & Aaltonen, 2011; Seikkula & Arnkil, 2006; Seikkula et al, 2003; Seikkula & Olson, 2003).

Compatibility of Approaches

The three meaning making approaches to psychosis that have been explored in this research are not mutually exclusive, and are perhaps, complimentary. An individual may derive benefit from the fellowship of a Hearing Voices group as well as from intensive one-on-one psychotherapy. Participants in Open Dialogue often engage in individual therapy along with the social network meetings. Open Dialogue as practiced in Western Lapland does not yet incorporate a peer component, but Seikkula and Sutela have expressed interest in exploring this possibility (Seikkula, Olson & Sutela, 2012). It's possible that the inclusion of peers in social network meetings could provide the person at the center of concern with an ally, and offer hope to both the person at the center of concern and their social network. Or perhaps certain individuals would prefer to have their network meetings be comprised of professionals and peers instead of family. As there is not one uniform experience of psychosis, there is likely no one way to address it. Offering options enables people to access the support they need, in the configuration that will be most effective in their personal healing journey.

Adaptability and Feasibility: what is possible here and now?

Sullivan, Fromm-Reichmann, Karon, Romme and the innovators of Open Dialogue have all offered empirical research substantiating the efficacy of meaning-making approaches to psychosis. However, in the United States, the medical model still dominates in the university, hospital, and public and private outpatient settings. Chapter Three examined a number of factors

that have served to construct and perpetuate the dominant discourse of the incurability of schizophrenia. These factors include: the financial interests of the pharmaceutical industry (Whitaker, 2010; Hornstein, 2009); Western post-enlightenment culture's privileging of personal agency, rational thought and empiricism (Castillo, 2003; McGruder, 2004; Taitimu & Lambrecht, 2012; Watters, 2010); the tendency to locate pathology in the individual rather than to address institutional and societal abuses of power with particular attention to continuing legacies of colonialism, slavery, patriarchy, and xenophobia (Jackson, 2002; Metzl, 2009; Sadowsky, 2004); family members who don't want to be "blamed" for the mental decompensation of other family members (Gibney, 2006; Olson, 2005); the clinicians' countertransference and aversion to joining with patients who are experiencing extreme states of terror (Fromm-Reichmann, 1939, 1947; Hornstein, 2000; Karon, 1992, 2008; McWilliams, 2011); and, relatedly, the great difficulty in accessing training in skillful application of meaning-making approaches to working with psychotic symptoms.

Given the powerful forces at play in the United States, how feasible is it to provide treatment that does not conform to the biological model? Both the Hearing Voices Network and Open Dialogue emerged in a context where the medical model and the biological discourse of schizophrenia were less entrenched, and in which psychosocial supports were more valued and supported by the social safety net. The c/s/x community and service providers are less polarized in Europe than in the United States where the pharmaceutical industry and managed care and a capitalist economy impede collaboration and communication (Hornstein, 2009). That said, while it doesn't enjoy the institutional support that its UK counterpart does, within the past several years, Hearing Voices USA has begun to support the development of user-led groups throughout the United States (HVN-USA, 2013). In the UK, with the support of the National Health Service,

the Network has been able to offer user-led trainings to a large proportion of service providers. Even if there was equivalent institutional support for such training in the US, it might be a more difficult feat in the context of our sizably larger population and geographic scope. Nevertheless, this network seems to be taking hold in the States and as clinicians we can seek to make these groups more accessible to our clients.

As we can see from above, the approaches of Open Dialogue and clinicians aligned with the interpersonal school offer an upfront investment of intensive resources to individuals and families in acute psychic distress. In Western Lapland, dialogical network meetings have become embedded in the entire social welfare and medical system (Seikkula, 2006). Finland's system of national health care makes network meetings and reflecting teams possible in a way that managed care in the United States discourages (Seikkula, 2003). Western Lapland has privileged long-term over short-term savings, which is not America's strong suit. As an American myself, I find it hard to imagine how the work-week might be organized so that clinicians would be available 12 days in a row to meet with a family; yet it has been done in Western Lapland, so why not here?

This year, in my work with Tikka, her family and the Open Dialogue influenced team, we did not have the institutional support to offer the consistency and frequency of care suggested by the principles of that model. We met with the family at most once a week. When Tikka was hospitalized she had a different treatment team than her outpatient team. She was pressured into taking medication that she did not wish to take. The innovators of Open Dialogue are informed by Bakhtin's dialogical theory that emphasizes the importance of context. They would not advocate the wholesale adoption of their model in a different context. While this is important to keep in mind, it can too easily be used as a loophole through which we can dilute the Open

Dialogue approach to the extent that it is easily adaptable to our system, and in so doing, get no real changes. Meeting with Tikka and her family once a week was not enough to create a sense of safety sufficient to avoid hospitalization and reliance on medication. Nor was it sufficient to engender a transformative dialogue in which Tikka's voices and unusual beliefs could be rendered comprehensible to her social network. However, even with the limited influence of Open Dialogue, from my perspective, some important gains were made. Tikka, who from the very beginning of treatment, shared that she wanted to be employed outside of the home, was supported in realizing this goal through the team's collaborative approach. I cannot say much more about gains made, as I did not have the opportunity to ask her to share her perspective about this, and though I no longer participate in the network meetings, they are still underway. As they are underway at her request, my sense is that this indicates that she finds them valuable. But there are many ways "her compliance with treatment" might be interpreted.

When speaking with other clinicians and service providers in Vermont, I have been cautioned that before making systemic changes at the state level, it is important to base these changes on small-scale successes. However, if an approach like Open Dialogue, whose beauty, in my opinion, is in its comprehensive and multifaceted approach, is replicated in a piecemeal fashion, this seems to me to be a set up for failure. It is important to remember that up until the 1980s Western Lapland had a model based on the biomedical model of schizophrenia as an incurable illness, with long-term hospitalization and chronic mental illness as the norm. They made a decision to completely reconfigure their system. Due to their comprehensive and up-front intensive approach to psychosis, in Western Lapland, there has been a dramatic decrease in new cases that meet criteria for schizophrenia (Mackler, 2011; Seikkula, 2002; Seikkula & Arnkil, 2006; Seikkula, Olson & Sutela, 2012; Whitaker, 2010). This indicates profound individual and

interpersonal healing, and eradicates long-term state spending on disability for a chronically mentally ill population.

What prevents us from advocating that we recreate our own micro and macro-system/s to do the same? With the theory and practice examined in subsequent chapters in mind, questions to ask ourselves include:

- How can we increase educational opportunities for mental health professionals to deepen their understanding of meaning-making approaches to out of the ordinary experiences (OOE's)/psychosis?
- How can c/s/x and others with lived experience of OOE's play a leadership role in shaping policy and programs to support those with OOE's?
- How do we foster a culture of collaboration between c/s/x and mental health professionals in the United States?
- How can we engage families and social networks of individuals at the center of concern in transformative healing practices rather than activating a culture of blame?
- How can we advocate for systems that offer the option of meaning-making and non-pathologizing approaches to OOE's/psychosis at the agency, county, state and national levels?

While vulnerability to psychiatric oppression cuts across all socio-economic strata in our society, members of marginalized groups (race, class, sexual orientation, gender identity, citizenship status, religious affiliation) are most at risk for both over-determined diagnosis rates of schizophrenia and the iatrogenic effects unequal treatment. As we conceptualize humane approaches to addressing psychosis we must attend to and counter our propensity to recreate the disparities in our society in our system of care.

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