***Commentary on <u>Psychotherapy as a Human Science:</u>***
***<u>Clinical Case Studies Exploring the Abyss of Madness</u>***

# The Humanity of the Psychotic Patient and the Human Approach by the Therapist: A Relational and Intersubjective Meeting

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## ABSTRACT

Atwood describes a relational, humanistic, existential, and psychodynamic approach to treating seriously mentally ill clients and calls for a restoration of psychology as a human science.  In our response, we echo Atwood's values and explore the phenomena of serious mental illness from the point of view of the patient's subjectivity and lived experience, contrasting it with reductionist and efficiency-oriented models of mental illness and treatment.  In our commentary, we extend his thoughts on treatment of psychotic patients through the lens of contemporary relational and intersubjective theories. We also discuss the place of this work in the current context.

*Key words*: subjectivity; meaning-making; case studies; clinical case studies.

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We have found in the most disorganized of people—
I believe the psychiatrist would agree that the schizophrenic
is the most disorganized of the functional mental illnesses—
a continuation of very much that is simply human.

-- Harry Stack Sullivan, *Schizophrenia as a Human Process* (1962).

Perhaps symptoms are messengers of a meaning and
will vanish only when their message is comprehended.

-- Irvin D. Yalom, *When Nietzsche Wept* (1992).

George Atwood (2012) imagines *"a world of psychiatry and psychology as a human science, one that has escaped the hegemony of the medical model and grounds itself in the study of human lives as they are lived and experienced"* (p. 14), and his paper brings alive what such a world might look like. Indeed, it looks a great deal like the lost world of Fromm-Reichmann, Searles, Semrad and Sullivan, but with a new theoretical grounding that has evolved from the ideas of intersubjectivity and relational psychoanalysis.

Through the cases he presents in this article, Atwood (2012) illustrates sensitive and sophisticated work with seriously mentally ill clients informed by phenomenological, existential, and psychodynamic theories and clinical practice, and he uses this work to call  for a restoration of psychology as a human science.  We will echo Atwood's sentiments and explore the phenomena of serious mental illness from the point of view of the patient's subjectivity and lived experience in contrast to reductionist, biologically driven models of mental health.  In our commentary, we will also explore further his treatment of his psychotic patients through the lens of contemporary relational and intersubjective theories as well as take a view of the place of this work in contemporary psychotherapeutic practice.

## THE SUBJECTIVITY OF THE PERSON WITH SCHIZOPHRENIA

Atwood's article describes a moment of epiphany he had when, as a relatively young therapist treating a floridly delusional patient (Grace), he understood deeply that symptoms have meaning.   He recognized, both intellectually and empathically, that Grace's "symptoms" were not just outward signs of an inward illness; they were efforts to psychologically survive, reactions to an ongoing experience of continuous abandonment and devastation at the hands of an uncomprehending world.  He developed, then, a therapeutic stance of trying to understand the "symptoms" of patients not as problems but as solutions to some crisis or catastrophe in living. The therapeutic task that ensues is to understand the phenomenological world of the patient in which such solutions make sense. Atwood writes,

> Psychotherapy, far from being any sort of procedure that is administered from a place of detachment, is always a dialogue between two personal universes, one that transforms both (p. 22).

Psychotherapy, then, must begin with a humanistic appreciation of the phenomenological world of the suffering patient. Ironically, a substantial part of the suffering of people with schizophrenia is constituted by others' (healthcare professionals, family, employers, neighbors, community at large) cultural ambivalence and reluctance to grant them full "human" status. This pervasive feeling of Otherness and denial of personhood is a cause of further social isolation and a sense of personal exile.

Macro-level evidence that the relational matrix is important in schizophrenia comes from cross-cultural studies. According to the three-decade long study from WHO (World Health Organization), people who have schizophrenia in developing countries tend to do better in the long term than people in developed nations (Hopper et al., 2007).  For example, in the WHO study patients in developing countries spent fewer days in the hospital, were more likely to hold jobs, participated in social communities, and presented more often symptom free.  The WHO experts believe the results favor the developing countries, because of the tight intact social networks—including the person with schizophrenia—that are an integral part of the local social milieu (Hopper and Wanderling, 2000; p. 843-844).  Intersubjectively speaking, it appears that people with schizophrenia in developing countries have retained their subjectivity and personhood to a greater degree than in developed countries, where the person with schizophrenia is often labeled as genetically defective and hence unemployable, bizarre, and socially undesirable.

# THE CONTINUUM OF HUMAN EXPERIENCES

In contrast to the current categorical approach to mental illnesses reflected in DSM-IV (APA, 2004), Fromm-Reichmann (1951) and Sullivan (1962) located schizophrenia in everyday social and cultural situations and underlined the continuity between the ordinary and the pathological,  emphasizing that they were not distinctly and categorically different.  Morrison (1999) suggested, as a specific example, that "auditory hallucinations are normal phenomena and that it is the misinterpretation of such phenomena that causes the distress and disability" (p. 298) often experienced by patients.  In a study comparing three groups—patients with schizophrenia, patients with dissociative experience, and non-patient voice hearers—Wahass and Kent (1997) found that the non-patient group, unlike the patient groups, perceived their voices predominantly positively.

Based on a review of published research, Bentall (2004), a British clinical psychologist, describes an apparent continuum from sanity to madness, arguing that psychosis might be thought of as the extreme end of a normally distributed spectrum of personality traits on which arbitrary cut-off points are imposed to separate those who are mentally ill from those who are not.  Recognizing commonalities between psychotic and normal experience—the "normalizing framework"—could prove useful both to the patient with schizophrenia and to the therapist. Echoing Atwood, Bentall (2004) writes that we need a radically new way of thinking of human problems—one that does not reduce madness to brain chemistry.

Geekie and Read (2009) critique the scientific literature that has attempted to develop theories of psychotic states without incorporating the subjectivity of lived experience.  As Atwood (2012) demonstrates, we can learn from our psychotic (and other severely mentally ill) patients about being human and be transformed.  Working with Grace, who found her own truth, brought him closer to a truth of his own.  In the era of the reductionist medical model where schizophrenia is perceived as a chronic "brain disease," a chemical imbalance within the central nervous system, a greater emphasis given to the everyday subjective experiences of the people with schizophrenia—both ordinary and extraordinary, lucid, and distorted—would teach us more about the psychological processes related to sense of self and its fragmentation than the current symptom-based diagnostic labeling that Atwood criticizes in the article.

# INTERPERSONAL TRAUMA AND RELATIONAL HEALING

The majority of people diagnosed with schizophrenia have suffered major traumas, such as early physical or emotional abuse, neglect, or loss (Read et al., 2003; Morgan and Fisher, 2007).  As was true for Grace, Atwood's patient, who at the age of 10 experienced her beloved father's brutal suicide, these childhood traumas represent a shattering of the relational world of the child (Stolorow, Atwood, and Orange 2002).  The restoration of the relational matrix (Mitchell, 1988) becomes a central therapeutic task with the psychotic patient. The relational therapist must develop with the patient a very human relationship based on trust against the backdrop of what the patient feels is a profound danger that impends personal annihilation. Atwood describes how he spent a great deal of time with Grace, visiting her almost every day for the first 6 or 7 months, sometimes for as long as two hours.  Grace had been brought up in a

family that had become traumatized and retreated to silence after the suicide of her father.  From the perspective of the relational therapist, the disturbing experiences need to be understood from within the interpersonal contexts in which they arise. The psychotic person's need is to have her subjective reality affirmed and validated by an empathically attuned other (Stolorow, Atwood, and Orange 2002).

In the case of Anna, another patient whom Atwood discusses, her mother's constant negative criticism, intrusiveness, and harsh judgment left her feeling invalidated, as research shows is common in the families of schizophrenics (Mueser et al., 1993; Leff and Vaughan, 1985; cited in Alanen et al., 2009).  This can lead to profound mistrust and fear of invasion by the other person, however benign they see themselves to be.  A critical aspect of the treatment is paying careful attention to the layers of the relational connection being made, tuning into the psychotic wavelength within both the patient and the therapist.  The issue is not just forming a "good relationship" but developing an exquisite sensitivity to the nuances of the intersubjective space that is created, sometimes over quite a long time, between patient and therapist. Grace could only respond as she did to Atwood's offer of salvation because she had spoken to him and tested his constancy almost daily over many months. The moment of transformation in Grace and the interchange that preceded it is dramatic and narratable; the months of listening, presence, and containment are often tedious, inscrutable, and hard to recount.

For any therapist, meeting with the psychotic patient can pose challenging encounters. The patient may come across as bizarre, withdrawn, and disinterested in social contact, speaking incoherently while filled with overwhelming anxious affect, possibly even hatred and despair. Atwood describes how Grace was angrily screaming at him, "Stop cutting me off, you're cutting me off, STOP CUTTING ME OFF!" (Atwood, 2012, p. 6).

A prominent symptom of the schizophrenic patient is her fear of closeness (Fromm-Reichmann, 1959).  The schizophrenic patient may evoke within the therapist severe anxiety and feelings of impotence due to lack of improvement (Fromm-Reichmann, 1959).  At the same time, as Searles (1963) points out, a therapist who feels the mainstay of his reality threatened may feel compelled to erect a defensive wall between his reality and the patient's, dismissing the latter's experience as madness, projective identification, or transference distortions, attributing such distortions to the operation of intrapsychic mechanisms located solely within the patient. Grace demands that Atwood stop cutting her off; Anna accuses him of trying to kill her. Such moments inevitably evoke strong emotions even in the seasoned therapist.

At the same time, as Fromm-Reichmann (1951, 1959) described, the psychotic patient is exceedingly sensitive, and suffering from profound loneliness in her despair (Sullivan, 1962). Atwood describes how Grace started to include him in her delusional stories and became very dependent on him for emotional support. Atwood's relational approach provided a container for her anxiety and connected with Grace through empathic validation.

As Atwood puts his epiphany, simply and elegantly, "It is truly incredible how far a little human understanding can go" (2012, p. 12). He makes it seem so accessible.  Understanding is a process, but the requirements of contemporary diagnosis suggest that we as therapists should know all there is to know about a patient in the first hour or two—as though patients can simply

tell us their dynamics. Therapists are now trained to document each session as progress toward a definable goal.  The valuing of therapy as a space for non-knowing, for holding the tension of uncertainty, for managing the anxieties created by the confrontation with inner demons—this is what is neglected in our rush for empirical validation (sometimes on a session by session basis). The containment function of psychotherapy has been undervalued, yet it is precisely such containment that allows the intolerable to be acknowledged, borne and placed in perspective.

Bion's (1962) theory of thinking involves a process of taking in, thinking feelingly about and thereby detoxifying the prevalent anxieties in a given situation which makes it possible for the empathic therapist to transform them, through reverie, from what he calls undigestible beta elements into alpha elements that can be thought about.  But doing this involves tolerating the anxiety of "not knowing" until some pattern emerges which can be put into words and formulated. This is one way of conceptualizing what Atwood did in his cases of Grace and Anna. With both, he sat with their delusions and the anxiety that doing so must have created, until he began to understand something about what the delusions served. The breakthrough moments required a long process of listening, presence and containment. Atwood, through his capacity not to "know," created a secure, grounding context for experiences his patients felt to be too irrational or confusing for them to bear alone.

Anxiety of this much intensity operates intersubjectively, such that the therapist shares the tension. In the case of Grace, it is possible that her ultimate challenge to Atwood created in him the anxiety necessary to drive him to consult with his supervisor and, from this consultation, reach a new understanding of what she needed from him.

Atwood writes,

> Overnight, as an apparent effect of 30 minutes of conversation, a raging paranoid schizophrenia, a volcano of florid symptomatology, had disappeared and been replaced by a perfectly normal person (p. 8).

This was his moment of transformative insight. But of course he knows that the almost magical change in Grace was not a direct result of the 30 minutes of conversation, but of the accretion of a relationship that grew over a long time.

> When I finally recognized the importance of standing up to her imperious grandiosity, and found a way to do so that would help her see she was in the presence of someone she could depend on, the destructive course of events in her life began to turn around.   Having discovered what she needed in our developing connection, the delusions and hallucinations receded.  Very gradually, in the crucible of her extreme dependence, the healing process that had been aborted years earlier in her life now had a chance to occur (p. 9).

This is a central insight in understanding what occurred between them—and the crucial questions are what occurred to make it possible for Atwood to "finally recognize" this, and if it is possible to teach this skill?

If psychosis is erected on relational trauma, the current treatment environment is structured to add a form of retraumatization.  The context of managed care, productivity

requirements for therapists, and mandated brief treatment have marginalized relational connection and understanding, and they privilege disembodied technique and action (Cramer, 2004; Beutler, 2000). The sense of urgency and documentation of efficacy have obliterated the value of uncertainty in psychotherapy.

These principles are well illustrated in Atwood's brief presentation of the case of Anna, a woman who felt annihilated by being told she was mentally ill, attacked by the insistence that she take medication, and assaulted by the psychiatric diagnosis of schizophrenia. Paradoxically, Atwood's effort to understand her recapitulated her experience of being "penetrated" by "rays" when she (given her exquisite interpersonal sensitivity) noted the confusion in his eyes as he tried to intellectually make sense of her delusions.

> I realized that when she looked into my eyes and encountered my confusion, she felt invaded and undermined.  Seeing my uncomprehending looks, she became an incomprehensible psychiatric object and lost all sense of her own personhood.  I understood now as well that she was symbolizing this felt violence in the imagery of the rays and the deadly solidifications.  She needed me to acknowledge the violence she was experiencing in a direct way; otherwise it could only continue (p. 12).

Once Atwood acknowledged this process with Anna, once he told her that he recognized that he too had indeed been, however unintentionally hurting her, her "schizophrenia" disappeared.  It seems that once Atwood moved from the more objective kind of knowing demanded in our current focus on diagnosis and treatment technique to an intersubjective, relational form of knowing, healing could take place. The current therapy environment, however, requires the objectification of patients through diagnosis, which then implies treatment protocols. Thus, how therapy is depicted publicly is very different from how it is experienced by the therapist.  Karon (2008), also working with an "incurable schizophrenic," writes,

> In my experience, much of every session makes no sense to me, or is repetitive; and what I remember is when things coalesce and become clear. But the reader should remember that every therapy hour is full of detail and confusion and repetitiveness, whose feel does not come through in concise case summaries (p. 4).

If there are rewards for groping toward one another intersubjectively, gradually recognizing one's own unwittingly traumatizing relational moves, and managing one's own uncertainty and anxiety in the process, then these rewards are personal rather than institutional. Imagine treatment notes that say something like, "Today I sat with the patient silently, engaged in reverie in which there came to me some possible inklings of the depth of her despair and isolation." How long would care review boards pay for such therapy? Institutionally we are asked to be experts who "know"—while good therapy involves holding the uncertainty of not knowing. It is nearly impossible to *validate* the effects of therapies which rely on an intimate (unscripted) therapist-patient relationship forged in genuineness and focusing on what spontaneously evolves (Yalom, 2002).

## MEANINGS AND KNOWLEDGE

Delusions are creative attributions of meaning to the experience of psychotic disintegration, mediated by narrative processes.  Laing (1964) observed that "the mad things done and said by the schizophrenic will remain essentially a closed book if one does not understand their existential context" (p. 15).  A narrative perspective on the construction of complex psychopathologies may not illuminate why they have occurred, but may shed light on their meaningfulness.  Roe and Davidson (2005) suggest that accepting plurality could help the unfortunately common invalidation of the patient by the therapist.  Acknowledging the existence of multiple, diverse views may be a necessary precondition for encouraging people with schizophrenia and other serious mental illnesses to compose and share their narratives.

Atwood notes through his case examples of Grace, Anna, and Mary that a key to the successful treatment of these patients was staying "experience-near" to the subjectivity of each person, finding ways of achieving a balance where the patient could feel personally validated, on the one hand, while aspects of the psychotic experience could be open to question, on the other.  As Atwood portrayed, with psychotic patients a mutual and respectful exploration of the meaning of psychosis within the context of a trusting relationship is critical (Read, 2004).  A shift from the position of knowing towards a genuine collaboration in exploring the nature and meaning of the experience would also be aligned with a truly relational approach to the therapeutic encounter (see also Aron, 1996).

Similarly, as therapists, we have to balance the societal demands to have knowledge and expertise with the therapeutic demands to be explorers, uncertainly inching toward relational meaning and connection with our patients (Yalom 2002). Therapeutic progress, as in Atwood's cases, is understood in retrospect; it is rarely scripted and planned. As Kierkegaard said about life, therapy is lived forward and understood backward.

Attuning to the psychotic wave length may constitute one of the most challenging tasks when working relationally within the intersubjective field with a psychotic patient.  As part of our humanness as therapists, we allow ourselves simultaneously to enter, while maintaining distance from, the phenomena we encounter. When empathically validating the experience of our psychotic client, a certain slippage between one level of discourse and another might have to be to tolerated (Eigen, 2004).  As Atwood notes in his case description, long-term successful work with a patient continuing to lucidly hallucinate does require both personal persistence and the professional ability to consult with peers and supervisors.  We hope that there will continue to be peers and supervisors who can resist the institutionalized demands of diagnosis and technique and represent the best values of a humanistically oriented approach to treatment.

Atwood envisions a more humanistic, existential, and psychodynamic future for psychotherapy, one that will investigate and illuminate the world of even highly psychotic patients. As we read this, though, we wondered how we left this path, a path marked by giants such as Fromm-Reichmann, Sullivan and the others whom Atwood mentions. How did empathic, phenomenological knowledge get washed away by the worship of empirical validation of observable symptoms and interventions?  The therapy that Atwood details in his cases is only

rarely available anymore in the United States, and the approach is even more rarely being taught in training sites.  Knowledge of treating psychotic patients with intensive psychodynamic psychotherapy, however, survives in the written case literature.  Fromm-Reichmann, in 1951, commented on the

> ever present affective interpersonal elements of the therapeutic process that unfortunately defy accurate scientific description at the present state of our knowledge and skill in accounting for these intangibles of the interpersonal interchange (p.xi).

She hoped that research would remedy this situation. Sixty years later, we have the development of intersubjective and relational theories that have given us language and concepts to detail better what these "intangibles" may be. And we have developed them largely through case-based narrative accounts such as Atwood offers here. These case studies encourage us to retain our appreciation for the affective and relational complexity of therapeutic intervention and a respect for taking time to understand the worlds of our patients.

## PERSON-CENTERED ALTERNATIVES TO THE MEDICALIZED APPROACH IN TREATMENT OF SCHIZOPHRENIA

The therapeutic dyad has always been embedded in a larger institutional world of hospitals and health care systems which implicitly construct the therapeutic relationship (Cramer, 2004; Shapiro, 2001).  When treatment duration is associated with productivity and profit, treatment goals acquire a hurried and somewhat harried character. Goals of transforming internal experience are replaced by behavioral change (Cramer, 2004).  With the current trend of medicalization of the treatment of the seriously mentally ill, general hospital psychiatric units have been transformed into extensions of emergency rooms, with "stabilization" of the patient with the help of pharmacology the goal—rather than getting to know the patient and crafting an individualized treatment (Silver & Stedman, 2009).

Even those patients who do respond to antipsychotic drugs have only a partial response, and they are left to cope with residual symptoms such as severe depression, impairments in social and vocational functioning, as well as with increased risk of relapses (Hietala, 2009).  It has now become more evident that both the old and new neuroleptics have serious and often even permanent side effects (Lieberman et. al, 2005; cited in Alanen et al., 2009).  There are, however, positive and evolving—though today rare and more likely outside the U.S.— therapeutic approaches that are anchored around the personhood of the seriously ill patient.

For example, in Finland Yrjö Alanen, a psychiatrist with psychoanalytic training also in the U.S., worked for over forty years with seriously mentally ill patients developing the "need-adapted" approach to schizophrenia. This model is anchored in the specific needs of the individual—combining intensive individual and family therapy and medication in low dosages, if needed at all (Alanen,1997). The fundamental approach within this treatment is the professional use of human interaction. In this context, the purpose of biological intervention, using so-called antipsychotic medication, is to calm the patient down to maximize the possibility for human interaction and psychotherapeutically oriented work. The aim is to help patients better reintegrate the many dimensions of their lives.  Data from several cohorts of patients, using therapy as part

of an integrated service, showed that the person-centered approach resulted in shorter inpatient stays and in lower dosages of medications (Alanen et al., 2009).  Also, this "need-adapted approach" compared favorably in terms of return to work and freedom from psychotic symptoms in a five-year follow up (Alanen et al., 2009).

Based on these positive results, the Finnish government has supported the widening of approaches that focus on intensive psychotherapy treatment, especially in the case of first-time psychoses. Seikkula and colleagues (Seikkula et al., 2006) have further developed this "need-adapted" model using a family and network approach aimed at treating psychotic patients in their homes in Western Lapland, a remote area of northern Finland with a high incidence of schizophrenia (35 new schizophrenia patients per 100,000 inhabitants [Alanen, 1997]). The principles governing this innovative work include provision of immediate help (within 24 hours) to prevent hospitalization, a social network perspective, flexibility and mobility, psychological continuity, stated tolerance of uncertainty, and dialogism (Bakhtin, 1984; Seikkula et al. 2006, p. 215). The overall focus is in creating a joint space in the form of a new language where things can begin to have a different meaning for the family, the patient, and treatment team (Anderson, 1997).  This bold and cost effective approach utilizes mobile crisis teams and integrates psychodynamic individual therapy, group work, aspects of family therapy, occupational therapy, and low-dosage pharmacological treatment. According to a follow-up study (Seikkula et al., 2006), 82% of the patients treated based on this integrated approach did not have any residual psychotic symptoms (high by international standards); 86% had returned to their studies or full-time job; 14% were on disability allowance; and only 29% had used neuroleptic medication in some phase of the 5-year treatment.

Between 1968 and 1980, as director of the Schizophrenia Branch of the National Institute of Mental Health (NIMH), Loren Mosher, a psychiatrist inspired by Semrad's work, developed a federally funded research demonstration project, "SoteriaHouse" (1971–1983). This was operated beyond its initial 10-month research term, but ultimately closed when funding dried up (Aderhold, 2009).  Soteria House was inspired by the phenomenological and existential approach to mental illness, emphasizing continuous human closeness with the psychotic patient ("being with"; Mosher, 1999).  Soteria's original aim was to assess whether a specially designed intensive psychosocial treatment—a relationship-focused therapeutic milieu incorporating minimal use of antipsychotic medications for 6 weeks—could produce equivalent or better outcomes in treating newly diagnosed patients with schizophrenia compared with a general psychiatric hospital ward model with antipsychotic medications (Bola & Mosher, 2003).

Though the original Soteria House in California closed, Mosher's model has been replicated by a Soteria House in Bern, Switzerland since 1984, and it is still in operation (Ciompi & Hoffman, 2004).  Empirical research (Ciompi & Hoffman, 2004) has demonstrated that this alternative approach in a small, supportive, and protective non-hospital setting has allowed for the achievement in Switzerland—like earlier in California—of similar or better therapeutic effects than with the traditional hospital-based treatment, almost without using antipsychotic drugs. There are, of course, many other examples of such approaches (e.g. the program at Austin Riggs); we here highlight just these few.

According to Calton and colleagues (2008), researchers from the United Kingdom, interest in "the Soteria paradigm" attempting to support people diagnosed with schizophrenia spectrum disorders using a minimal medication approach is growing across the industrialized countries.  The recent systematic review by Calton et al. (2008) suggests that "the Soteria paradigm" yields equal, and in certain specific areas, better results in the treatment of people recently diagnosed with schizophrenia spectrum disorders when compared with conventional, medication-based approaches. These investigators call for further research in "whole-person" paradigms in order to generate valid, cost effective, and legitimate future treatment alternatives to persons diagnosed with schizophrenia and other serious mental disorders. Aligned with this search for pragmatic approaches incorporating patient views, Tansella (2010), an Italian psychiatrist, concluded that "we need to listen more to our patients, to talk more (and better) with them, and to make our style of working in hospital and community facilities less paternalistic" (p.3).

While the massive expansion of managed care, pressures on confidentiality, and the pharmaceutical revolution in mental health care have shaped the contours of the therapeutic dyad, it is still possible to find ways to adapt the principles that Atwood articulates—as the examples cited earlier confirm—into the context of available resources of time and money.  A fundamental belief that symptoms have meaning and that the recognition, understanding, and articulation of these meanings will promote growth and lasting mental health can still guide the therapeutic enterprise. This will, however, involve a greater appreciation of the complexities of the intersubjective dialogue that is the therapeutic dyad and a greater tolerance for "not knowing" at any given point in the therapy whether "treatment goals" are being met (see Yalom, 2002).

## THE HEALING POWER OF VALIDATION

Seasoned clinicians aver that for the therapist to work successfully with a psychotic patient, the therapist should possess humility (Fromm-Reichman,1959), be free of narcissistic preoccupations (Searles, 1963), and be equipped with a fine sensitivity to the overt meaning of human communication (Eigen, 2004) while knowing that "we are all much more simply human than otherwise" (Sullivan, 1953, p. 16). The sensitive therapist is able to offer validating and healing responses that the patient was denied during her earlier times by family and immediate environment (Lapsley et al., 2002; Vellenga and Christenson, 1994).

First person narrative accounts may, then, be of utmost importance in assisting the developing therapist to understand the world of psychosis (Drayton et al, 1998).  Beneath the surface of what appears to be "flat affect," for example, may be an intersubjective failure representing a clash between the perspectives of the observer and subject resulting in terrifying and suppressed intense emotions (Tarrier et al., 1979). There is a compelling case to be made that in deepening our comprehension of the complex and confusing experiences of psychosis, a greater emphasis be given to voice of the lived experience.  First-person accounts (e.g. Greeenberg, 2009; Saks, 2008; Sechehaye, 1970) and narrative and phenomenological research enhance our understanding of how to best work with those troubled by psychosis.  And, of course, case presentations that emphasize the subjective experience of both patient *and* therapist, such as Atwood offers here, are both the heritage and legacy of this artful, relational approach to

healing. As Atwood says, (and it bears repeating) "It is truly incredible how far a little human understanding can go."

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