

***Response to Commentaries on Psychotherapy as a Human Science:
Clinical Case Studies Exploring the Abyss of Madness.***

The Abyss of Madness and Human Understanding

GEORGE E. ATWOOD^{a,b}

^a Department of Psychology, Rutgers University.

^b Correspondence concerning this article should be addressed to George E. Atwood, Tillett Hall 509, Livingston Campus, 53 Avenue E, Piscataway, NJ, 08854
Email: ufoatw01@earthlink.net

ABSTRACT

Two pairs of authors—Pienkos and Sass (2012) and Josselson and Mattila (2012)—have commented upon my article, "Psychotherapy as a Human Science: Clinical Case Studies Exploring the Abyss of Madness." In the article I present a number of case studies that illustrate a phenomenologically, humanistically, and existentially and psychodynamically informed approach to severe psychological disturbances, including both so-called schizophrenia and so-called bipolar disorder. I appreciate the common sympathy that both sets of commentators have with the concept of psychotherapy as a human science. The commentaries also help to raise a number of issues around the concepts of "phenomenological contextualism," "radical otherness" in so-called schizophrenia, the conflict between phenomenological and medical disorder language in describing severe disturbance, and challenges to a psychotherapist working with severely disturbed individuals.

Key words: phenomenology; psychosis; schizophrenia; bipolar disorder; humanistic psychology; therapeutic relationship; psychodynamic theory; case studies; clinical case studies

**PHENOMENOLOGICAL CONTEXTUALISM AND THE ABYSS OF
MADNESS: RESPONSE TO PIENKOS AND SASS**

I thank Elizabeth Pienkos and Louis Sass (2012) for their careful and appreciative reading of my essay. I experienced their commentary not as criticism, but rather as a set of interesting reflections from kindred spirits. What follows are some thoughts that came to me in the process of going over their commentary.

Phenomenological Contextualism

The authors of the commentary repeatedly describe the approach to psychotherapy illustrated in my paper as *humanistic*, and this they contrast with another viewpoint referred to as *phenomenological*. I think of myself as combining elements of both of these alternatives in a

phenomenological contextualism, a perspective that has gradually come into being over the course of many decades of collaborative study, primarily with Robert Stolorow (Stolorow & Atwood, 1979; Atwood & Stolorow, 1984; 1993), but importantly as well with Bernard Brandchaft (Stolorow, Brandchaft, & Atwood, 1987) and Donna Orange (Orange, Atwood, & Stolorow, 1997; Stolorow, Atwood, & Orange, 2002). Born originally of studies of the subjective origins of psychoanalytic theories, this way of understanding has arisen out of our efforts over more than three decades to rethink psychoanalysis as a form of phenomenological inquiry and to illuminate the phenomenology of the psychoanalytic process itself. Our dedication to phenomenological inquiry, in turn, led us to a contextualist theoretical perspective, from which personal worlds of emotional experience are always seen as embedded in constitutive relational contexts.

This evolution has had profound consequences for our understanding of psychoanalytic theory and of the varied phenomena it seeks to address, including our conceptions of psychological structure, of the unconscious, of psychological development, of dreams, of trauma, of psychopathology in all of its variations and degrees of severity, and of the psychotherapeutic process. Phenomenological contextualism is a post-Cartesian viewpoint, dispensing with a view of the person as an isolated mind, a thinking thing having contents that looks out upon a world from which it is essentially estranged. Instead, the legacy of the philosophy of Descartes is replaced by a broadly based set of assumptions on which the person is seen as always inhabiting a world that provides the context for his or her experiences, a world itself understood as saturated by human meanings and purposes.

“Radical Otherness” in So-Called Schizophrenia

Pienkos and Sass seem to suggest that the case descriptions and accompanying conceptualizations in my essay, emphasizing the power of human understanding, somehow underplay the strangeness, the absolute “otherness” reported by many observers upon encountering so-called schizophrenic patients. The experiences of such patients may, according to their argument, depart so radically from those of the therapist as to challenge the very possibility of a meaningful empathic connection, giving rise to a sensation of extreme strangeness, a scary “*praecox feeling*.” After spending a great many years preoccupied with the problem of understanding madness, here is what I think about this issue.

I regard the sense of radical otherness generated in the observer of so-called schizophrenia as an illusion, and it occurs because the observer lacks the knowledge needed in order to make the experiences involved comprehensible. What is this knowledge? It consists in a thorough understanding of annihilation states and their typical symbolizations, which include the disturbances of “*ipseity*” remarked on by the authors. It also includes a familiarity with the concretization or reification process, in which subjective experiences and symbols thereof are recast as tangibly existing in physical reality.

Let me recount a clinical story of a patient who was considered impossibly strange and certainly beyond the reach of anyone’s empathy, but whose experiences turned out to express a very destructive but decidedly human set of circumstances. This was someone who triggered not “*praecox feelings*” but rather “*praecox alarm bells and sirens*.” She was 55 years of age and

was hospitalized after attempting to forcibly enter the home of Harry Truman, then living in Independence, Missouri. The patient explained she had traveled from New York City to Missouri in order to “retrieve” her head, which she was sure was in the possession of the ex-President and was being kept somewhere in his house. When it was gently pointed out to her that her head was just where it should be, on her shoulders, she loudly screamed: “Truman!...Truman!...Truman!”

There was more to her tale of woe. The Con-Edison Power Company in New York had conspired with Truman to destroy her, by constructing immense tube-shaped machines kept in secret locations. These machines, pointing upward toward the sky, generated powerful “yellow rays” that traveled through the atmosphere, and descended upon her and penetrated her vagina. The energies of the rays then “percolated” upward through her body and into her throat, where they caused “a small man” to materialize. This “man in her throat,” in turn, periodically seized control of her voice and interrupted her conversation with cursing and yelling. As hospital staff members tried to speak with her, a frightened look would pass across her face and she would cry out: “Whoop ... whoop whoop...Holy Moses! Holy, Holy, Holy Moses!” Such expressions were followed most often by a pleading question, also shouted out: “Did you hear that? That wasn’t me! I am a good girl! I would never say ‘Holy Moses!’ That was the little man, the man in my throat Whoop Whoop ... whoop ... Holy, Holy Moses!”

I wish I could say that I helped this patient, but at the time of our contacts, more than 40 years ago, my understanding of annihilation states had not yet crystallized and I was still working within a Cartesian model of mind and its relation to objective reality. Her experiences seemed too strange to be reached by any empathy I could muster, although my failure was not for lack of trying. Naively—I was only 24 years old at the time—I sought to imagine her world as she perceived it, picturing in my mind what I might feel if I found myself without a head and my body invaded by the frightening yellow rays. For a period of several weeks I sat with her, listening carefully to every detail of her story and trying to identify with her agony. No change in the delusions occurred as a result of this effort, although I did see a growing attachment to me as we spent more and more time together. A slight, barely visible smile would appear when I arrived for our meetings, a look of sadness when I left after an hour. During our times together she described in excruciating detail the process by which the energy of the machines’ rays moved through her body and produced a foreign agency lodged in her throat. She named this process with an apparent neologism: “*warmeling*.”

Finally, the psychiatric authorities in our crisis-oriented inpatient service elected to transfer the patient to a state hospital for the chronically mentally ill. At our meeting in which I informed her of this plan, she began to cry and seized my arm: “Please, please Dr. Atwood! Be careful of the ‘warmeling!’ Please don’t let it get you!”. I felt she cared about me and was trying to be protective. As she spoke in this way, I began to feel a trembling and a stirring in my lower abdomen, as if the energies had somehow entered into my body as well. This effect, rather disturbing in the moment of its occurrence, arose because of the deep identification with the concretizations of her experience I had been attempting to cultivate. Clinicians seeking to empathically identify with their severely disturbed patients, but without benefit of understanding the reified symbols that may be involved, put their own psychological stability at some risk.

Projecting oneself into the literal content of a delusional world helps neither the patient nor the therapist, because it misses the subjective truths the delusions concretize.

I never saw this patient again, but I kept copies of her records and was also able to look at biographical material collected during a previous hospitalization. Over the ensuing decades I have repeatedly reviewed these records and finally was able to my own satisfaction to discover the human meaning of her strange delusions. In retrospect, I have found that the “otherness” she seemed to display—the “praecox feeling” she elicited—has vanished and she instead seems to me to have been the victim of a profound family tragedy. She had been born and raised in Germany, living through the chaos of both world wars. Siblings had died in the military conflicts and her family had lost everything and been forced to move from place to place like penniless nomads. There was one constant in her young life though: her father, a man of enormous narcissism who abusively insisted on an attitude of absolute compliance from his wife and surviving children. He was an epistemological tyrant, demanding total agreement with his views on all things great and small as a condition of maintaining any connection to him. If my patient or her siblings, as children, dared to voice their own separate opinions, they would be accused of unforgivable crimes and were violently attacked. The patient did comply with her father through most of her childhood, always working hard to be a “good girl” in his eyes. There were no overt signs of psychological disorder until she emigrated to the United States after the end of World War II.

What were the experiences that were symbolized in this patient’s paranoia? My understanding, only arrived at many years after I had seen her, is that she had suffered a massive psychological usurpation of her mind at the hands of her father. This lasting trauma of her childhood was expressed first of all by the delusion that her head had been taken from her, and secondly by the image of an invasion of her body and the appearance of a man in her throat. This entity assumed control of her “voice,” extinguishing her capacity to speak her own mind and say her own thoughts. The imagery developed by this patient is an instance of the “influencing machine” delusion discussed originally by Tausk (1917). The unmistakably phallic shape of the long tubes sending rays into her vagina appears to depict a rape. It is my view that the primary meaning of this invasive imagery lies in an experience of a rape of the soul rather than one of the body. It can be said of this patient that she was the sister of Daniel Paul Schreber (1911), whose surrender as a child to the autocratic, profoundly usurping abuse and domination of his father was also symbolized in the image of being attacked by penetrating rays from on high (Schatzman, 1974; Orange, 1994). The use of the figure of Harry Truman as her supreme persecutor may relate to the ex-President’s name: Truman—True Man—the Man with the Truth, the Truth to which one must surrender one’s own mind.

Would it have been possible to help this patient in a psychotherapeutic relationship? My psychiatric colleagues at the time thought not. I believe such an undertaking would have been worthwhile, focusing on themes of invalidation and usurpation, supporting her efforts to (re)find a measure of autonomy (and ipseity) in the functioning of her mind. I have no illusions this would have been easy; it would probably have required a commitment of many years.

Extreme psychological disturbances often present themselves in obscure, incomprehensible forms. And yet, no matter how difficult what is expressed may be to

understand, these conditions remain, in their essential being, human events arising out of human contexts. But it is not just that. When we listen to the human stories told by our most disturbed patients, we also rediscover aspects of ourselves. It has been a central aim of my lifework to erase the sharp boundary that has been drawn to separate madness from sanity, returning the phenomena of severe psychological disorders to the circle of the humanly intelligible (Atwood, 2011).

The Medical Model and the Abyss of Madness

One feature of Pienkos and Sass' discussion distressed me: their relatively frequent use of terms deriving from the medical model of diagnosable mental disease entities. Their title refers to "mental illness," and in the body of their text there are references to "patients with schizophrenia" and "symptoms of psychosis." At one point, after praising my thinking and case descriptions, they say my phenomenological and humanistic approach provides "a necessary counterpoint to the dominant, often overly simplistic medical model of mental illness" (Pienkos & Sass, 2012, p. 29). Are they favoring some sort of balanced view combining both perspectives? Such language raises the question in my mind as to whether they harbor a lingering investment in the medical model running counter to their otherwise exemplary phenomenological commitments. Do the authors think of schizophrenia as an actual disease process having some kind of objective existence, as something a patient can "have?" Then I would ask: Is so-called bipolar disorder, in their eyes, itself a psychiatric illness importantly deriving from underlying biology? Is the medical terminology employed really just a shorthand with no intrinsic significance, or does their commentary show the subtle presence in their thinking of a hybrid of incommensurable medical and phenomenological language games? I was unable to definitively answer these questions on the basis of reading their words.

My students often ask me my opinion of psychiatry's understanding of madness—of contemporary diagnostic systems with their differentiations and classifications—with a view of the various forms of madness as identifiable disorders or diseases. I answer as follows: the ever-proliferating systems of nomenclature in psychiatry are among the field's most serious embarrassments, and nowhere as disturbingly as in the efforts that have been made in the study of madness.

Madness, as I understand it, is not an illness, and it is not a disorder having any kind of objective existence. Madness is the abyss. It is the experience of utter annihilation. It is the fall into absolute nonbeing. The abyss lies on or just beyond the horizon of every person's world, and there is nothing more frightening. Even death does not hold a terror for us comparable to the one associated with the abyss. Our minds can generate meanings and images of our deaths. We can picture the world surviving us, and we can identify with those who come later or otherwise immortalize ourselves through our works. We can rage against the dying of the light, and we can look forward to reunions with lost loved ones. We can think about the meaninglessness of human existence and its finiteness. We can be relieved that all our sorrows will soon be over. We can even admire ourselves for being the only creatures in existence, as far as we know, to perceive their own wretched destiny to be extinguished. The abyss of madness offers no such possibilities. It is the end of all possible responses and meanings, the erasure of a world in which there is anything to respond to, the melting away of anyone to engage in a response. It is much

more scary than death, and this is proven by the fact that people in fear of annihilation—the terror of madness—so often commit suicide rather than continue with it. Death is a piece of cake compared to the abyss.

Am I saying that everyone, all of us, are forever on the threshold of madness? No. I am saying that the abyss is a universal possibility of human existence. Most of us spend our lives in a stable and sane worldview that does not bring us, subjectively speaking, to the doorway to madness. Our sense of our own security is steady, supported and sustained by the network of validating, affirming connections we have to others; in fact, it is such a given part of the bedrock of our lives that we never really think about it. That does not mean, however, that the sanity we enjoy in our cozy little worlds cannot be taken from us. It can, because we all are capable of falling into the abyss. Something might happen, and then the center cannot hold.

UNCERTAINTY, COMMITMENT, AND LANGUAGE: RESPONSE TO JOSSELSON AND MATTILA

My response to the commentary by Josselson and Mattila (2012) is very similar to the one after reading the remarks of Pienkos and Sass: these are once again kindred spirits with deep sympathy for a phenomenological way of understanding severe psychological disturbances and with a shared commitment to the idea of psychotherapy as falling within the human sciences. I thank these authors for their careful reading of my article, and for their sensitivity in going over various aspects of the clinical cases I describe. The thoughts that came to me in reflecting on their words fall into two areas: the first concerning the necessity for the psychotherapist to tolerate great uncertainty and sometimes long periods of stress in working with severe disturbance; and the second pertaining to the authors' continuing use of medical and diagnostic language, even as they engage in serious efforts to support a humanistic and phenomenological approach.

1. Bearing the Unbearable

I agree with everything Josselson and Mattila say about the importance of bearing with our patient's experiences, often over very long periods of time, even when what we are seeing and hearing leaves us in a state of distressed confusion. In this era of manualized therapeutic procedures and demoralizing discussions of so-called evidence-based treatment, the patience and dedication required for successful clinical work in difficult cases is very challenging, to say the least. It might be of interest to the readers of my comments to hear some elaborations on what I went through in the early stages working with my patients Grace and Anna, whom I described in the target article (Atwood, 2012) of this *PCSP* issue. Here are some stories that tell what it was like.

I shall start with Grace, the woman who was intensely overwhelmed by Catholic images and themes. Becoming involved with this young woman, on an essentially daily basis for the first six months, was like riding a volcano. I was at the beginning of my clinical career and had never met such a person, and yet here I was, charged with her care. I remember thinking I just had to throw myself into the work, and wait to see what transpired. Among the many specific themes on which she expounded, there was the Pope in Rome and his relationship with the College of

Cardinals as Grace prepared for her beatification; the origin of the Catholic Church many centuries ago; the terrible suffering of Christ during the crucifixion; the incomparable love and devotion of Saint Mary; the historical neglect by Catholic theology of the human side of Jesus in favor of the divine; the imminence of the Second Coming of Christ; and Grace's central claim to be the incarnation of the Holy Spirit and therefore to embody God Himself by virtue of the mystery of the Holy Trinity. I remember listening to her disquisitions, often shouted out to me, and feeling overwhelmed by the sheer power of it all.

Many months passed before I was able to rise above the force of Grace's passionate convictions and demands, and respond to the deep inner cry for help which they expressed. It is difficult to describe my many reactions to the early onslaught of her great struggle. I recall feeling battered, coerced, and deeply invalidated and intimidated by her vociferously presented religious certainties—were it not for the support I was receiving at the time from my consultant and mentor Austin Des Lauriers, my journey with Grace may well have come to a disastrous end. Had I succumbed to the pressure I felt and terminated our contacts, there is little doubt she would have experienced another in the long series of abandonments making up her emotional history. What happened between us taught me a principle that I have seen confirmed again and again in later years: If you hold on long enough and just refuse to give up, things will eventually turn around. After Grace and I had our breakthrough, the work with her became easy, even a joy as I watched her healing recovery during the ensuing years. This is very often the pattern that is followed in the therapy of the most seriously disturbed of our patients: an initial period of struggle, seeming regressions, almost overpowering stress for both patient and therapist—followed by breakthrough and a long period of recovery that is comparatively free of turmoil and a joy to participate in.

Parallel difficulties occurred in my work with Anna, the woman who experienced death-rays emanating from the eyes of her persecutors and turning her brain into an inert object. The reader will recall that Anna saw these rays began at a certain point to flow forth from my eyes as well, precipitating a deep crisis in our relationship. A long period went by during which our meetings were filled with tension: Anna pleading for a release from the invasive, petrifying rays, and my feeling accused of raping and murdering my patient's brain. I wish I had words to describe how terrible this situation was for her, and how awful it was for me. She was undergoing the killing off of the core of whom she was, and my identity as a healer and really as any kind of caring person was being assaulted and disconfirmed for days and weeks and months. I fought to stay with what was happening by talking to myself, saying such things as:

George, you know that the only hope is your everlasting commitment, so just bear with it!,
[or] This ship may be going down, Atwood, but you are riding it all the way to the bottom,
so take a deep breath and keep on keeping on!

I remembered something Des Lauriers told me and used it to comfort myself when feelings of hopelessness about the therapy sometimes enveloped me. He had said that if a therapist tries hard enough and suffers long enough, the patient will eventually feel sorry for him and get better if for no other reason than this one. I longed for that day to come.

A few weeks before the breakthrough Anna and I finally reached, one summer afternoon a year and a half into the work, I stepped out of the office we had been using and encountered a

psychiatrist I had met but did not know well. The meeting Anna and I had just finished had been utterly brutal. That day was extremely hot and humid, and the air conditioning of the hospital had failed. I felt depressed and beaten up, and I was drenched with perspiration. Here is the dialogue that occurred:

Dr. F. Dr. Atwood, are you trying to do psychotherapy with that patient [pointing toward Anna]?

G.A. Trying is the operative word. I am not sure there is much therapy that has been happening here.

Dr. F. Don't you know that patient is schizophrenic?

G.A. Yes, I believe the diagnosis appears on her chart.

Dr. F. Aren't you aware that schizophrenics cannot be helped by psychotherapy? They have a brain disease causing delusions and hallucinations, and the only treatment that works for them is pharmacological. They have genetic predispositions and they have a neurochemical disorder. What in the world are you doing?"

G.A. I am trying to work with her, and maybe you are right. I thank you for your thoughts.

Dr. F. These are not thoughts Dr. Atwood; it is a matter of established knowledge.

G.A. I hear you, my friend.

One might wonder how it was that I was being so accommodating to this gentleman, who after all was espousing the very biological reductionism that I strongly dislike and find to be scientifically indefensible. As I walked away from the brief conversation, the words of the psychiatrist kept running through my mind: "schizophrenia," "neurochemical disorder," "genetic predispositions," "cannot be helped by psychotherapy." I found myself responding unexpectedly positively to these assertions. I then heard a voice, within myself, crying out loudly, and shockingly: *YES! SHE IS SCHIZOPHRENIC! SOMETHING IS WRONG WITH HER BRAIN! NO ONE COULD HELP HER! NO PSYCHOTHERAPY IS POSSIBLE AT ALL! OF COURSE NOT!* The feeling accompanying these reductionist thoughts was one of freedom, relaxation, almost euphoria. But then a further reaction set in. I was horrified by my own readiness to embrace such assumptions, and was left wondering about the meaning of the whole situation in which I had found myself. What had happened to me to bring about a conversion, however momentary, to the medical-diagnostic model and its objectifications and reductions? After reflecting on this issue for a long time, here are my conclusions.

Anna had subjected me to what one might call an "epistemological assault," challenging my self-definition at its most basic levels as I listened to her imagery, but without understanding the annihilation experiences it symbolized. I was hearing it literally, concretely, tangibly. She was telling me with as much passion as Grace had shown about the Trinity that I was heartlessly murdering her brain and her soul. She was saying as an incontrovertible truth that because of my violence, she was dying and she was dead.

The dialogue of psychotherapy is a world within the world, and within that smaller world very terrible things can happen to both people involved. If so-called schizophrenia is believed to be a brain disease, I now began to see, the therapist is released from the epistemological claim on his or her reality by the patient's so-called delusions and hallucinations. The psychotherapist is not guilty of soul murder; he is just a caring clinician being misconstrued by someone who is very ill. Could it be that the very concept of schizophrenia as a diagnostic entity is and always has been embedded in an intersubjective context like the one I was experiencing with Anna? This would be a context including attacks on the clinician's sense of what is real on the one side, and a countervailing objectification of the patient serving to shield the clinician on the other. The therapist's self-protecting response includes an attribution of the patient's experiences and epistemological assaults to an internal biological factor: a disease, a neurochemical defect existing inside the patient's nervous system. The patient's subjectivity is thereby dismissed as anything to be taken seriously in its own right and reductively explained away. Anna was telling me rays from the eyes of her enemies (including my eyes) were projecting influences into her brain, turning it into a dead thing; and what she needed more than anything was for me to see the subjective truths symbolized in her visualized, concretized agonies, and to take responsibility for the destruction that was occurring. When I finally did so, as described in my target article (Atwood, 2012), the crisis dissolved and we found ourselves on a better footing.

Clinicians need to think about the impact on the patient of the perspective that is taken in perceiving and interpreting whatever is presented. When that perspective is medical and objectifying, the patient may experience an invasive annihilation or persecution in which his or her very subjectivity is felt under siege. We also need to think about what such a perspective does *for the clinicians themselves*, which can include a shielding against epistemological assault by discrepant subjective worlds.

2. Language: The Words We Use Matter

Josselson and Mattila, like Pienkos and Sass, freely use the term "mental illness." They also often refer, without apparent hesitation or qualification, to "symptoms," "psychosis," and "schizophrenia" as something one may "have." Although I certainly also sometimes fall into a diagnostic-medical language, I am troubled by the use of such words; and I think we should give careful attention to the ways in which our manner of speaking may influence and even subvert the thinking we are trying to advance. The language we use both expresses and constrains the thoughts that we have, and if our words oscillate between the medical and the phenomenological, so will our thinking, and we may well find ourselves lost in the collision between incommensurable universes of discourse.

For example, Josselson and Mattila entitle one of the sections of their essay, "Person-Centered Approaches to the Treatment of Schizophrenia." The term "person-centered" suggests, to me, a concern with phenomenology, with the person understood as an experiencing subject and agent. "Treatment" and "schizophrenia," on the other hand, refer to procedures that are administered and to an illness from which one suffers. Is their phrasing oxymoronic? Does it lead inexorably to a muddle and incoherence in our efforts to think through what is required to give a human response to the greatest crises that can occur in human lives? For this reason I most often qualify my use of medical language with the words "so-called." This is a poor

solution to the overall problem, however, and I am frequently guilty of the offense for which I am criticizing them anyway. What our field needs is a much more developed phenomenological vocabulary that can do justice in an internally consistent manner to the human experiences we are trying to understand.

In my target article (Atwood, 2012), I try to imagine a world in which the hegemony of the medical model is superseded and an experience-near set of concepts and terms takes its place. Rather than speaking of diseases and disorders, we will concern ourselves with subjective catastrophes, with personal crises, with enduring dilemmas and captivities to trauma that destroy the quality of our lives. We will think not of “treatment” and “illness,” but rather of human responses and human meanings. This new world will have little room for words like “schizophrenia,” “mental illness,” and “psychosis,” which I foresee becoming relegated to a dark age of our history. The subjective disasters to which these words are assigned will not however be neglected in any way; on the contrary, they will be studied and understood in their human contexts as never before. One effect of such studies, I believe, will be the erasure of the sharp boundary that continues to be drawn to separate madness from sanity, returning the phenomena one sees in severe psychological disturbances to the circle of the humanly intelligible.

REFERENCES

- Atwood, G.E. (2011). *The abyss of madness*. New York, N.Y.: Routledge.
- Atwood, G.E. (2012). Psychotherapy as a human science: Clinical case studies exploring the abyss of madness. *Pragmatic Case Studies in Psychotherapy* [Online], Vol. 8(1), Article 1, 1-24. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal
- Atwood, G.E., & Stolorow, R.D. (1984). *Structures of subjectivity: Explorations in psychoanalytic phenomenology*. Hillsdale, N.J.: Analytic Press.
- Atwood, G.E., & Stolorow, R.D. (1993). *Faces in a cloud: Intersubjectivity in personality theory*. Northvale, N.J.: Aronson.
- Josselson, R., & Mattila, H. (2012). The humanity of the psychotic patient and the human approach by the therapist: A relational and intersubjective meeting. *Pragmatic Case Studies in Psychotherapy*, [Online], Vol. 8(1), Article 3, 36-48. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal
- Orange, D.M. (1994) *Emotional understanding*. New York, N.Y.: Guilford.
- Orange, D.M., Atwood, G.E., & Stolorow, R.D. *Working intersubjectively: Contextualism in psychoanalytic practice*. Hillsdale, N.J.: Analytic Press.
- Pienkos, E., & Sass, L.A. (2012) Empathy and otherness: Humanistic and phenomenological approaches to psychotherapy of severe mental illness. *Pragmatic Case Studies in Psychotherapy*, [Online], Vol. 8(1), Article 2, 25-35. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal
- Schatzman, M. (1973) *Soul murder: Persecution in the family*. New York, N.Y.: Random House.
- Schreber, D.P. (1911; 2000). *Memoirs of my nervous illness*. New York, N.Y.: New York Review of Books.
- Stolorow, R.D., & Atwood, G.E. (1979) *Faces in a cloud: Subjectivity in personality theory*. Northvale, N.J.: Aronson.

- Stolorow, R.D., Brandchaft, B., & Atwood, G.E. (1987). *Psychoanalytic treatment: An intersubjective approach*. Hillsdale, N.J.: Analytic Press.
- Stolorow, R.D., Atwood, G.E., & Orange, D.M. (2002). *Worlds of experience: Interweaving philosophy and psychoanalysis*. New York, N.Y.: Basic Books.
- Tausk, V. (1917). On the origin of the influencing machine in schizophrenia. *Psychoanalytic Quarterly*, 2, 519-556.