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Commentary on: Portrait of a Man Imprisoned in an Altered State of Consciousness: The Case of "Sean"

Virtual Realities: On Delusion, Shame, and Intersubjectivity

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ABSTRACT

In our contribution, we note the remarkable nature of Dr. Michael Garrett's (2020) case study of "Sean" and of the rich therapeutic relationship he so eloquently describes with his client. We then discuss several overlapping topics: the question of diagnosis and functional considerations, the patient's attitude toward his delusions, and certain issues pertaining to the therapeutic relationship.

Regarding diagnosis: we ask about the extent to which the patient "Sean" might or might not qualify as a case of schizophrenia. It is not clear from the report that Sean demonstrates the widespread disturbances of perception, cognition, and affect that would be expected in prototypical cases of schizophrenia. His psychopathology seems largely bound up with his delusions or delusional system, and these latter do not seem distinctively "bizarre." We suggest that "Sean" might better be viewed as a case of delusional disorder (while recognizing the vagueness of the boundaries between these and other conditions).

We examine Sean's attitude toward his delusions in some detail, asking whether this seems in keeping with what is assumed by the standard poor-reality-testing formula that is adopted in mainstream psychiatry, psychoanalysis, and the CBT approach to psychosis. The standard view assumes that a patient's delusions, though false, are *believed* by him or her, and that the delusional objects or events are experienced as having the ontological status of something truly real (existing in the objective and intersubjective world). In our view, evidence suggests that Sean did not in fact experience his own delusions in this literalist way, but implicitly recognized their purely subjective or "virtual" nature. In light of this, we question the appropriateness of adopting the standard CBTp approach to this aspect of his psychopathology. The success of the treatment may be more intimately bound up with the relationship-building aspect (e.g., with Dr. Garrett's skillful use of humor and perspective-taking) than with the empirical or logical refutation of his delusional preoccupations that CBTp theories would seem to emphasize. There are interesting parallels between the treatment of delusions in psychotic patients and the progression of theories in science described by such philosophers as Kuhn and Lakatos.

Finally, we consider an additional aspect of the therapeutic encounter: namely, the avoidance of issues (well-advised, in our view) that could provoke or revive a sense of inferiority

or humiliation in the patient (that is, of shame concerns). This is one of many demonstrations of this therapist's remarkable skill, discernment, and capacity for empathy.

Key words: psychotherapy of psychosis; psychotherapy of schizophrenia; CBTp (cognitive-behavioral therapy of psychosis); delusion and belief; phenomenology of psychosis; phenomenology of delusions; double bookkeeping in delusion; delusional disorder and schizophrenia; case study; clinical case study.

INTRODUCTORY COMMENTS

This is a beautifully written narrative and reflection on a remarkable case and a remarkable treatment. It shows unusual sensitivity to the patient or client, an ability to develop a personal relationship under difficult circumstances and a constant willingness to make every effort on the patient's behalf. We are grateful for the opportunity to comment here on the work of a master clinician who is also a major theoretician regarding the psychotherapy of psychosis. Reading the case history provides one a vivid three-dimensional picture of the complexities of two individuals working together. The author's forthright descriptions of his thinking underline the common finding that the interpersonal chemistry between patient and therapist significantly influences clinical progress.

Our first reaction after finishing the case was in fact to wonder what we could say, beyond expressing fascination with the client and admiration for what Dr. Garrett was able to accomplish. Naturally that would not provide a commentary of any great interest; and so, instead, we will raise a number of questions – some admittedly based on impressions, even speculations. Perhaps these may provide some potential routes for the self-questioning that is always possible (and often worthwhile) in the always uncertain domain of psychotherapy.

In our comments below we will address several overlapping issues, in the following order: the question of the diagnosis and functional considerations, the nature of the delusions presented, and finally, some issues pertaining to treatment and the therapeutic relationship.

DIAGNOSTIC AND FUNCTIONAL CONSIDERATIONS

One may wonder: what is the appropriate diagnosis here? Sean has had various labels applied to him, including schizophrenia, bipolar, and schizoaffective disorder. Some clinicians will dispute the importance of diagnostic considerations, but we think that, at the very least, they can help focus our attention more closely on some of the specifics of the symptoms and experiences at issue.

We would note that we do not find the classic "stigmata" of schizophrenia to be very prominent in this case write-up. The delusion itself seems to be by far the dominant characteristic of the psychopathology that Sean displays, and we wonder whether this might best be seen as a case of delusional disorder. We would also note that Sean may not fit all that well some of the standard or classical phenomenological accounts of schizophrenia; and this is because it is not clear that his problems begin with an overall transformation of the perceptual field akin to what has been called the "delusional mood."

It would be useful to know about the onset and sequences of the clinical changes. It is not uncommon, in cases of schizophrenia, for there to be an initial delusional mood that is accompanied by perplexity and a diffuse sense of foreboding—a feature that is well described in the literature of phenomenological psychopathology (summarized in Sass & Pienkos 2013). These features can be important not only diagnostically, but for their biographical significance. The "what in the world is happening?" response may produce a before-and-after landmark, in the sense that subsequent beliefs or quasi-beliefs associated with the delusions can sometimes be understood as ways of introducing a greater sense of coherence into a person's story, and thereby as dissipating the often highly uncomfortable sense of precariousness and confusion inherent in the delusional mood. By the time we meet Sean in this report, any such earth-shaking sense of encompassing uncertainty or imminence that might (or might not) have been present, seems to have been replaced by abnormal beliefs that, for all their implausibility, nevertheless have a workaday quality.

It is hard to know for sure; but our sense, from reading the information available, is that Sean's hyper-salience experiences (the report speaks of "a hyper-salient experience of ordinary events" [Garrett, 2020, p. 144]) are actually quite circumscribed, pertaining to the car horns and the bird calls on Monday mornings. Given these limitations, we wonder whether they might be viewed as being more the *consequence* of a delusional or quasi-delusional focus (which might itself encourage a period of hyper-focused attention) than of a more pervasive or deeply grounded, overall disturbance of self and of world. This point might apply as well to Sean's experience of his thoughts being available to others. We are less sure about these abnormal experiences of thinking, yet these too seem to be quite circumscribed, both in time of occurrence and in terms of who is felt to be witnessing them.

All this could suggest that this patient's psychopathology might have more in common with pure paranoia (delusional disorder) than with true paranoid schizophrenia. (We recognize however that, as so often in psychopathology, the boundaries are likely to be fuzzy rather than sharp: perhaps Sean is a paranoid schizophrenia patient whose paranoid features are simply more prominent than his schizophrenic or "disorganized" ones.) Also we are not sure how clearly present is the fundamental disorder of minimal or basic self that is so typical of schizophrenia (and that would be accompanied by alterations of one's sense of "grip" or "hold" on the experiential world)—and which is bound up with what Dr. Garrett, citing Sass and Parnas (2003), describes as "a diminished sense of the self as the first-person 'I' at the center of experience, along with a hyper-reflexive self-awareness of one's mental processes" (p. 144).

We would also note that Sean's delusion does not seem to be of the paradigmatically or distinctively schizophrenic type in the sense of not being particularly "bizarre"—at least in many of its aspects. The preoccupation with being in a relationship with a Hollywood actress, e.g., has a wish-fulfillment-like quality that would not be difficult for an average person to be able to imagine, and in this sense to empathize with. As we shall see below, however, the quality of Sean's belief in this delusion or quasi-delusion is rather ambiguous.

It would also be of interest to have more information on the nature and extent of Sean's functional decline as his psychosis became prominent. A pronounced prodromal decline in functioning might be more consistent with schizophrenia, as traditionally understood. More

significant still would be information providing a better grasp of Sean's attitude expressed toward his diverted life trajectory. One may ask, for example, whether the retreat into delusions should be understood primarily in negative terms, namely, as a way of escaping the painful disappointments of life, or whether we need to adopt a more complex account of the positive psychological contribution offered by the delusion or delusional world at issue: Did Sean experience an accumulating sense of failure that drove his interests toward the wished-for greater tractability of his delusional involvements— an escapist flight toward anything that might put distance between himself and his painful failures to negotiate the developmental challenges of his early twenties? Or, was there something specifically motivating about these particular delusional preoccupations, attracting his commitment by providing "solutions" to the puzzles posed by unsettling pathological overall changes in his experience?

THE NATURE OF THE "DELUSION" AND THE "DELUSIONAL WORLD"

We suspect that, as a psychiatric educator and supervisor, Dr. Garrett shares our experience of the challenges in introducing the notion of delusion to trainees. The concept of "delusion" is surprisingly difficult to define with any precision, yet typically delusions are not difficult for an experienced clinician to recognize. In some respects, they resemble beliefs, certainly, and often seem to have propositional content, but they do not share all the common characteristics of normal beliefs: e.g., often they are not acted upon. (Historian of psychiatry German Berrios has gone so far as to ask whether they merit being called beliefs at all (Berrios, 1991).) Most experienced clinicians, we suspect, do take notice of the content of a delusion (e.g., when classifying it as bizarre), yet may give greater weight to abnormalities of form, to the *way* in which the person relates to the apparent belief.

To the observer, Sean's claims regarding the CoF (the "Committee of Four") might at first seem to involve straightforward truth claims—of the sort that would fit what might be termed the standard "poor reality-testing" formula, with its assumption that delusions involve truth claims to which the patient is committed even though these claims are false in objective or intersubjective terms. Sean does state that the CoF is "real," "really there" etc., and he says: "Doc, this is real!"; or "But that's not my situation. The horns are real, Doc." On reflection however, it may not be so very clear what these statements actually imply about his own orientation or attitude toward the delusions. The last two quotations might, for example, be interpreted less as literal truth claims, regarding something the patient fully accepts as real, than as a way of rejecting the feared possibility that the clinician, Dr. Garrett, might somehow attempt to demote or diminish the "reality" or the importance of his world. It may be a way of saying, in effect, "I see what you're doing or might do, and I don't want you to take this away from me by imposing your way of defining reality."

Dr. Garrett describes Sean as being "imprisoned in a virtual reality" (p. 132). A good question to ask, however, is whether this background sense of something being "merely virtual" (that is, not fully *real* in the standard sense of that word) may actually be *experienced by Sean himself*, even though the fact may never directly be admitted.

Here is a brief excerpt from the case study which suggests that Sean may indeed be already aware, on some level, of the merely virtual nature of his delusion. In the lead up to this exchange, Dr. Garrett had told Sean about another patient of his, "Patient Z."

> T. [I told Patient Z that] you [Patient Z] think that a million people know about you.
>
> P [Sean]: They do! (he chuckles)
>
> T: That's what you [Sean] say. That's what he [Patient Z] used to say. He used to say everybody in Brooklyn knew about him because he could see it in their eyes that they knew.
>
> P: Not everybody in Brooklyn. [Sean said this with a slightly droll way, as if to say, "Come on! Everybody!? You have got to be kidding."] (p. 169).

Sean's chuckling, and the droll manner which was apparent to the therapist, suggest that Sean is aware, in some fashion, of the absurdity, and therefore, of the probable lack of literal reality, inherent in what he says—at least from the standpoint of his interlocutor. Here Sean seems willing to see something a little silly in his own stance, yet without actually renouncing or walking away from it.

At several points, it is also striking to note that Sean seems to *recognize* that components of his delusion came out of his own head. It is noteworthy as well, however, that his recognizing of this fact does not seem, for him, to count against what he at least might call the truth or "reality" of his delusion; their ontological status nevertheless does seem rather ambiguous. At one point, Sean states, regarding his fantasy object: "No. I know that I put her there." At another point he states, "Okay. Yes. As soon as I thought of them, they were there. They were just there" (p. 183). The latter statement suggests that Sean could *not* experience these delusional objects as having the same objective weight as normal real-world beings would be felt to have. The very fact that he is conscious of having put the beings there with his own thoughts (and that they only appeared at that moment) suggests that he must sense, at some level, that these beings are *not* like the typical objects and persons of the real world, which would not of course depend in such fashion on one's own subjective thoughts. In this way Sean does not, in fact, seem to treat or to experience the CoF delusion as if it were akin to a normal belief. Indeed, one might be tempted ask whether he does not, in some sense, betray or otherwise indicate his own ontological doubt, and respond protectively to Dr. Garrett's challenges, when he insists, as he does from time to time, that it is all very real. All this might suggest that, in fact, his delusional realm is *not* in fact fully real for him; and that, perhaps, he "doth protest too much" when he claims that it is.

We should not be surprised, then, by the fact that Sean can often seem reluctant to subject his delusions to the possibility of refutation by empirical evidence: it may well be that he knows full well, and in advance, that, as truth claims, they would fail such a test in the objective and intersubjective world of normal reality. If this is indeed the case, it would suggest that what Eugen Bleuler called a kind of "double bookkeeping"—a simultaneous living in the real and shared world and in the imaginary world of the delusion, without confusing the two—can be present even when the patient does not explicitly acknowledge this fact (Sass 2014).

To make such a claim does not imply, by the way, that the patient could rightly be said to

be merely *pretending* to believe in his delusions, or something of that nature. The somewhat equivocal form of experience that may be present is suggested by one of our own patients who explained to one of us (JW) the irrelevance of the reality-testing framework by insisting "Don't you see they [the delusional beliefs] are in my mind *and* they are real." This comment shows that awareness that one's own mind may have in some sense 'birthed' a delusion need not bring in its wake a sense that something is simply not real—at least not in any simple or straightforward sense.

We would suggest that what seems characteristic of many (not all) patients described as having delusions may be less a matter of some incapacity for "reality-testing'' (as is assumed in much of mainstream psychiatry as well as in CBTp) than a matter of something more like attitude or orientation: namely, the presence of some fundamental failure or refusal to commit to the basic reality of practical life in an intersubjective world. Moreover, if viewed longitudinally, such a withholding of commitment to practical life can elevate the importance and meaning of a delusion, as the delusion is required, less and less, to compete for mental prominence with practical, quotidian concerns. As a person ages, the world of practical engagement can come to resemble a ghostly memory, ceding space to the delusional alternatives. At this point, it would be more correct to say that *neither* the delusional nor the actual world is experienced by the patient as having the full quality of reality (rather than arguing, with the poor-reality-testing formula, that the delusion is taken as "real").

But if it is the true that the patient experiences at least a background sense of the unreality of his delusional world, then it is not so clear that "imprisoned" is quite the right word to employ (as when Dr. Garrett speaks of Sean being "imprisoned" in a "virtual reality" or an "altered state of consciousness"); for this might suggest that Sean's delusional reality is in some ways a chosen or at least *quasi*-chosen reality. Dr. Garrett is aware of this, certainly, but we wonder whether he may put a bit too much emphasis on the ways in which a punishing superego *imposes* itself while perhaps neglecting some of the ways in which the delusion may serve certain escapist purposes.

The issue of escapism is not straightforward, however. Delusional realities are sometimes considered to provide a kind of wish-fulfilling alternative reality, in which the unpleasant or frightening circumstances of the patient's real-world experience are substituted by fantasies of success or of physical safety, fantasies that (in accord with the poor-reality-testing formula) are *believed*--albeit mistakenly—by the patient who entertains them. In *The Psychology of Imagination,* the existential-phenomenologist Jean-Paul Sartre writes of another alternative which he terms that of the "morbid dreamer" (Sartre quoted in Laing, 1965, pp. 84f; see also Sass, 1994). Sartre describes the condition of the morbid dreamer as involving an attempt to escape *not the content but the form of the real*. Such a person is motivated (according to Sartre) not so much toward believing in the reality of a world that is more satisfying than the actual one, but, rather, toward experiencing himself or herself as living in a world that is recognized precisely *as unreal*, and that is appealing for just this latter quality. The framework of the delusional world would be implicitly felt by such a patient to be one that does not presuppose the pervasive uncertainty of actuality (and the anxiety this implies), and that does not demand the real-world responses that are part of our normal existence.

We certainly recognize that Dr. Garrett's view on these matters is complex and nuanced;

and we fully agree with the following statement from his report: "Therapists working with psychotic patients would do well to distance themselves from the familiar binary dichotomy, 'Is it true or is it false?' and instead see the patient's delusional assertion as at variance with consensual reality, but nevertheless subjectively true" (p. 152). In one passage Dr.Garrett states, "*Sean understands that the Council is appearing in an imaginary space*" (p. 186). Amen to that. We wonder, however, whether the full *ontological* complexities of Sean's delusional condition (meaning the way in which the patient himself experiences them as real or unreal) are sufficiently considered in Dr. Garrett's account.

Some of Dr. Garrett's statements, as well as his adoption of the CBTp paradigm for treating delusions, do seem to suggest that he is inclined to accept the applicability to this case of the standard poor-reality-testing formula, with its assumptions both that delusions are fully believed and that they are false. This seems to be implied by Dr. Garrett when he writes, e.g., that "CBTp is a superior method for examining the literal falsity of delusional beliefs" (p. 136), or when he describes his goal as being that of "helping the patient entertain doubts about the veracity of the delusion, in the spirit of CBTp" (p. 137). Dr. Garrett states that "CBTp relies on logic to examine maladaptive beliefs, with the aim of developing alternative explanations for the patient's anomalous psychotic experiences" (p. 136).

But we have suggested that the patient Sean may already entertain doubts, at some level, about the reality of his delusions, or at the very least, may experience them as existing in a realm somewhat cut off from the standard realm of confirmation and refutation in objective or interpersonal circumstances. It seems, in fact, that Sean is able to grasp the logical implausibility of his delusion almost from the outset of the treatment (and before that, we would guess); but it may well be that he does not wish to dwell on this dimension of doubt. This would suggest that the issue pertains more to the realm of will or motivation than to that of one's capacity to use logic or assess evidence as emphasized within the CBTp approach. If this is the case, then we think the standard CBTp focus—on encouraging doubt about the veracity of the delusion—may be somewhat beside the point.

A final, somewhat incidental point regarding Sean's delusions concerns the possible difference between what might be termed the Megan versus the CoF (Committee of Four) aspects of his delusion. From Dr. Garrett's report, it seems that Sean was more open to entertaining the possible *un*reality of Megan than of the four men of the CoF—as implied in the following statement by the therapist: "So why is Meg different?" asks Dr. Garrett. "You see her in the frame, but you know that she isn't actually there. Why don't you think you are imagining the Council?" (p. 183). This point might be juxtaposed to the statement, quoted above, in which Dr. Garrett states, "Sean understands that the Council is appearing in an imaginary space" (p. 186). Here we encounter something that may seem contradictory—given that the Council is described *both* as something that is *not imaginary* and also as something that appears in an imaginary space.

We wonder whether this difference between Megan and the CoF might be related to the different kinds of roles, of *epistemological* roles, that they play. It seems that Megan largely functions in Sean's delusional universe as an *object* of awareness, of desire in fact, whereas the CoF guys are experienced by Sean more in the role of being *subjects* of awareness, indeed as

subjects whose *own* object is usually Sean himself (whom they are engaged in monitoring and criticizing—something that Sean himself also does). The CoF men do not, then, in any sense appear directly, even in Sean's "mind's eye," so to speak. They are experienced *as* consciousnesses, and as such, may not have even a minimal sort of objectification that might make it possible for their reality to be doubted. This is only a speculation, but it does suggest it could be important to introduce a distinction between two kinds of delusional beings: those that have the quality of an object of awareness, of what Sartre termed the "*en-soi*" or "in-itself," versus those that are more like felt consciousnesses, having the being of the "*pour-soi*" or "for-itself." Could it be that the less object-like qualities of the latter make them especially difficult to confront or to test in any empirical or quasi-empirical manner?

PSYCHOTHERAPEUTIC PROCESS, AND IMPACT

The CBTp rationale for treating psychotic delusions tends to emphasize something akin to a demonstration or at least an exploration of the irrationality of the delusion at issue. An alternative formulation might emphasize, not so much the illogicality of the delusional belief, or its failure to be consistent with empirical observations, but rather, the more interpersonal issue of the degree to which the patient is committed to living in a shared or intersubjective field. In the case of Dr. Garrett's psychotherapy with Sean, one may ask whether the key therapeutic element concerns, not the logical or empirical arguments he offers, but rather, the forging of an interpersonal relationship that, in a sense (this is an exaggeration), just happens to have the delusional content as its frequent focus.

Much of what Dr. Garrett actually does in the treatment can be seen in the latter kind of light—as, for instance, when he asks Sean what Sean thinks about what he himself, Dr. Garrett, might be thinking. At another point Dr Garrett speaks of attempting to get Sean to adopt something like the role of a therapist, albeit toward other persons: "*In effect," he writes, "I am trying to enlist Sean to do CBTp on other people with the aim of his insight about others ultimately being available to his assessment of himself"* (p. 167). Also conducive to establishing such a sense of intersubjective connection is the sharing of humor and irony, which is such a prominent and an impressive feature of this treatment. Moves like this seem to have been characteristic of this rich therapeutic encounter; and they would certainly seem likely to invite the patient back into the intersubjective field.

In a way, in fact, this treatment actually might demonstrate the limitations of going directly at the delusion in the classic CBTp fashion, given that, despite Dr. Garrett's best efforts (including his almost herculean, albeit always diplomatic, attempts to convince Sean of the irrationality of his delusions), the patient at the end has *still* not fully distanced himself from his delusions. Sean, writes Dr. Garrett, "is as deeply entrenched in his psychosis as any patient I have encountered in two decades of psychotherapy practice" (p.139), and it is by no means clear that this fact changes greatly over the course of the treatment. On the other hand, the patient does seem to show some significant clinical improvement; but this may largely result from the nature and importance of the human relationship that developed between Sean and Dr. Garrett. What seems likely to have been effective may have very little to do with the set of rational or empirical arguments that are offered, in the CBTp aspect of the treatment, and far more to do with the impressive human relationship that Dr. Garrett and Sean were able to build with each other.

CONCLUDING REMARKS

Above we have emphasized the patient Sean's quasi-awareness of the ways in which certain kinds of doubts could be entertained without surrendering his beliefs, and also the ways in which his claims for the reality of his delusional world seem to operate differently than would claims for the reality of more quotidian beliefs. This makes us wonder about the value of adopting the cognition-focused approach of CBTp, with its focus on logic and evidence. Contradictory evidence can indeed leverage existing doubts, especially when provided with the tact and timing so characteristic of Dr. Garrett's style. But as most clinicians know, many delusions can evade falsification by seemingly ad hoc changes in the scope of their claims, creation of special meanings, or the rationalization of exceptions, and so forth. Most clinicians have seen examples akin to the (perhaps apochryphal) story of the doctor who, when his patient insisted he was dead, told him "Look dead men can't bleed," and pricked the man's finger, only to see the patient conclude "What do you know, dead men can bleed."

We would suggest that the reality-testing falsification cognitive model might bear a resemblance to Popperian models of progress in science. By contrast, the reconfiguration prompted by a well-placed psychodynamic interpretation, and by a rich interpersonal encounter, may have more in common with Thomas Kuhn's famous notion of paradigm shifts in the course of scientific revolutions. As in science so in the psychotherapy of a psychotic patient, an altered attitude toward certain beliefs may occur not as a result of rational or empirical arguments, but rather, because new paradigms or programs of understanding come into play—and this latter may need to be understood as involving a more holistic kind of change.

To extend this parallel from the philosophy of science, one might even contemplate a third alternative, consisting in shifts or alterations driven neither by falsification nor by paradigm shift. As the post-Kuhnian philosopher Imre Lakatos points out, when a set of theories or a general scientific approach dries up, and quits producing interesting things to investigate, we can speak of a "degenerating research program"—which scientists eventually abandon (Lakatos, 1978). Following the analogy, might not a patient simply walk away from a delusion that had ceased to provide guidance for the sort of life he is living, particularly if he has been enabled to lead a richer, engaged life not dependent on his delusions.

Yet another analogy might also be apt. While some people can recall rejecting an earlier religious belief, based on insufficient evidence, or falsification of a religious claim, many move away from their faith without ever seeing its claims refuted. Instead they find that as they craft a life in a secular age, and no longer call on beliefs they once honored, the beliefs could be said to fade away from disuse, rather than being refuted.

As a final point, we would note that the remarkable quality of the human relationship that develops may have something to do with the fact that Dr. Garrett seems to say little by way of refuting the positive side of the delusion, namely, the unlikelihood of a famous actress being interested in a person like Sean, or of Hollywood being interested in a book deal about Sean's life (indeed, we don't even know whether Sean expects to write this himself—all this is left remarkably nebulous). Dr. Garrett seems to have sensed that, perhaps especially between two men, a focus on either of these topics, with their potential for humiliation, would undermine the

therapeutic alliance.

We note, in fact, that Dr. Garrett focuses on issues of guilt and not those of shame: together they do "guilt work" not "shame work"—and this seems a wise therapeutic choice. On this kind of issue, Dr. Garrett writes eloquently:

> In my clinical experience, spirit-witheringly poor self- esteem is the most common psychological driver of delusional narratives. People who break down in psychosis in adolescence and young adulthood feel themselves to be failures in life. The majority of psychotic persons hear voices, and the most common voice reiterates the person's worthlessness. For some, a rapid illness onset and steep decline from higher functional levels produces suicide. Those majority of those who adapt hear voices, and the most common voice reiterates the person's worthlessness (p. 148).

The guilt focus is captured in the following excerpt from the case:

> I hope that in the long haul of the therapy process, he [Sean] will internalize me as a caring Oedipal father who is trying to provide him some guidance, whose standards aren't so punitive as those of the CoF. I expect that if he comes to see me in this way, his need for the CoF has a good chance of declining (p. 162)

All this is well and good, for it seems appropriate that Dr. Garrett stayed well away from issues that could cause a sense of narcissistic mortification (shaming). On the other hand, one might wonder whether issues of shame might be, at bottom, even more profoundly at the core of Sean's problems and in particular of his withdrawal from the world of normal competition and normal satisfactions, with its potential for losing, indeed for being a "loser" (hence for what will be experienced by him as extreme humiliation), in favor of a world in which there is the hope of a kind of utter transcendence of all such risk. (This is not to say, however, that Dr. Garrett was not wise in avoiding too much focus on these latter issues—we think he was quite correct in this decision.)

These reminders of the suffering wrought by psychotic illness once again point beyond the psychotherapy, toward other therapeutic elements that might be developed. To the extent our earlier speculation is correct that his impoverished environmental circumstances, and restricted activities outside the therapy, contribute to fragility, and the sense of limited choices, it may point up the importance of roles not tied to his illness.

As Sean ages, and his parents decline, will his Brooklyn community offer him resources, a valued place, and a reason to wake up in the morning? In our "psy" vocabulary, these might be labeled "psychosocial supports." They could as easily be considered essential elements for a person trying to find worth in his life—although in our upside-down care system, who would provide the resources needed, if they produced no billable services? The public psychiatry developed in the last third of the 20th century was animated for some by a vision that the benefits of the best of the therapeutic asylums could be recreated in the community. The shortcoming of our underfunded system can be a dismal thing to contemplate, here in the richest nation in the history of the world, but it is inspiring, and a source of hope, to see how humane intelligence is applied by clinicians such as Dr. Garrett.

Dr. Garrett's uncommonly transparent and reflective account of this challenging treatment is an act of generosity to the field—as are his past theoretical contributions, beautifully summarized in his recent book on the topic (Garrett, 2019). In an era too marked by clinical pessimism regarding serious mental illness, his work is a stirring demonstration to a new generation of clinicians that providing psychotherapy to psychotic patients is a challenge worthy of their best efforts.

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