

**The Intersubjective Dyad and Empathy:  
A Therapist's Phenomenological Experience  
With a Psychotic Patient**

by

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Abstract

Working with a person who suffers with a psychotic disorder in individual psychotherapy can be challenging, frustrating, ineffective, and emotionally draining for both the client and clinician. But, it may also be an extremely rewarding therapeutic relationship and process, which promotes positive and permanent insight and change. This case study of a therapeutic relationship with a young woman suffering from schizophrenia is a combination of my 30 years of work as a psychiatric social worker in the field of mental illness, and the many men and women who courageously sought help for a wide spectrum of psychiatric disorders. It shows how an empathetic treatment approach created a safe environment for the client's self-exploration and fostered her ability to make changes and heal from some of schizophrenia's debilitating symptoms. A humanistic and empathetic approach allowed me to maintain a self-reflexive and intersubjective position, a position that is often dismissed by strict evidence-based strategies.

*Keywords:* psychoses, schizophrenia, empathy, intersubjective, phenomenological

*You want me to call up  
Something so desperate that the thought of it  
Wrings my heart before my tongue can speak.*

– Dante, *The Inferno*

*I did not blame Alice for her illness. I felt powerless and inept at times, never quite sure if our sessions were helping. I did not have a clear understanding of what was going on in Alice's mind. I felt frustrated because I was having difficulty interpreting Alice's rants, and even more frustrated that she could not understand or accept any of my suggestions and interpretation of her issues.*

This paper is for any mental health professional who has never experienced or treated a client suffering from psychosis, and would like a firsthand account of what it is like to be in a session with someone diagnosed with schizophrenia. By encapsulating and synthesizing the data of decades of work, I conceived of this client, who I named "Alice." She is a composite of the men and women I treated over my 30 years in practice who courageously sought help for a wide spectrum of psychiatric disorders. The timeline, interactions, and majority of the story were all lived experiences by clients, their families, and/or me. Due to privileged withholding to protect the individuals' identity, I have taken some poetic license in this paper.

Over my many years in practice, I learned that what was paramount to the success of my work with clients who suffered from some form of psychoses was more than just years of psychotherapy training and academic achievements. It was the ability to know when it was time to just listen compassionately, validate their feelings, be a witness to their pain and suffering, and self-reflect.

Empathy, and allowing for the intersubjective experience, are sometimes the only tools therapists have available to help our clients. By intersubjective, I mean that Alice and I brought our interacting worlds of experience together. I brought my knowledge and skill from years of working with the mentally ill, along with a subjective perspective. Alice brought a combination of her eight years of lived experience with schizophrenia, and her incredible hope and determination to return to normalcy and reconnect to the parts of her life that were erupted by madness.

*\*Privacy Disclaimer: To protect the confidentiality of the client, identifying information has been disguised and certain details have been concealed.*

## The Intersubjective Dyad and Empathy

This united effort created a shared phenomenon. George Atwood, one of the early authors of intersubjective theory, sees psychotherapy as a dialogue between the therapist and the client, and any or all change or process that takes place in the therapeutic dyad happens because of the “intersubjective field,” which Atwood defines in his book, *The Abyss of Madness*, as one that “creates a constitutive context for the experiences and actions of both analyst and patient.” (2012, p. 35)

Schizophrenia can be a frightening and unexplainable mental illness, and the mere mention of the word can send chills down the spine of even the most acclaimed and skilled psychotherapist. After a therapy session with a client diagnosed with schizophrenia, I often was emotionally drained by the constant barrage of bizarre delusions, disorganized thoughts, fragmented speech, or endless parade of paranoid plots. I was frustrated numerous times by a lack of measurable goals, and I questioned my motives for continuing a relationship with a client(s) who, according to a medical model of psychotherapy, would be diagnosed as untreatable or labeled a poor prognosis. I struggled often with this ethical debate.

But, there were even more times when I felt confident that our consistent encounters, my patience and emotional availability, my understanding of their language during times of disorganized thinking, and my ability to interpret delusions to reduce distress helped penetrate the obstacle of psychosis. Some clients were only able to remain engaged for a brief 30-minute session in a process where their “sanity was sustained” (Atwood, 2012, p. 43).

Atwood refers to this phenomenon in *The Abyss of Madness*. He writes: “Sanity is sustained by the network of validating, affirming connections that exist in a person’s life: connections to other beings” (2012, p. 43). Although the clients I saw in my private practice came from very supportive and involved families, on many occasions I was the “being” to whom the client felt the most connected.

Developing a bond, and utilizing an empathic approach, is never an easy task with someone who suffers with a psychotic illness. It is a very challenging, and, at times, daunting obstacle to not only engage in, but continue an ongoing therapeutic relationship. As Douglas Hollan reminds us, “Empathy is an ongoing, dialogical, intersubjective accomplishment that depends very much on what others are willing or able to let us

understand about them” (2008, p. 394). Here lies a major problem when working with the grossly psychiatrically disabled: They are not always willing or able to “let us in.” But don’t give up if they don’t! The empathetic and humanizing approach I utilize has been the foundation and catalyst for change and positive therapeutic outcomes for many of my clients.

I am by no means suggesting that manualized, evidence-based approaches offer little help in the treatment of the severely mentally ill. But I am stating that if I had not been open to a more intersubjective empathic approach, what transpired during my work with many severely mentally ill clients would have had a very different outcome. No matter what modality of treatment a clinician adopts or practices, I undisputedly believe that to increase the treatment’s effectiveness, it is vital to incorporate the strategy of understanding and a collaborative approach under the umbrella of empathy.

Early in my training, I was introduced to, and influenced by, psychodynamic theory. But I developed and became skilled in Systems Therapy, and have a solid understanding of Cognitive Behavioral Therapy. As I grew as a therapist, I used a more eclectic approach with my diverse caseload. Irvin Yalom, an existential philosopher psychotherapist, argues against a singular theory of therapy in his book, *Love’s Executioner*. He writes, “The powerful temptation to achieve certainty through embracing an ideological school and a tight therapeutic system is treacherous: such belief may block the uncertain and spontaneous encounter necessary for effective therapy” (1989, p. xxii).

Similar to Yalom’s perspective, and in support of my approach with many of my clients, Warren S. Poland affirms, confirms, and strongly identifies the importance of not only the intersubjective connection with the client, but also the witnessing of their process and respecting their individuality. In his article, *The Analyst’s Witnessing And Otherness*, Poland writes, “It is the action of the analyst as a witness, one who recognizes and grasps the emotional import of the patient’s self-exploration in the immediacy of the moment, yet who stay in attendance without intruding supposed wisdom – at least not verbally” (2000, p. 18).

In the following vignette, I hope to show, by example, not only what Poland refers to regarding the “patient’s self-exploration in the immediacy of the moment,” but also my phenomenological

experience of self-reflection during a session with a person suffering from schizophrenia.

There are many theories regarding why some people who suffer from schizophrenia become more symptomatic over time, with few to no periods of stabilization, while others might have one hospitalization with no recurring prominent positive psychotic symptoms. Unfortunately, Alice did not fall into the latter category. There is no one reason why Alice was never symptom-free. Perhaps it was due to the early onset of the disease, genetic predisposition, a neurobiological defect, a bout with encephalitis at age 12 that caused her to become anxious shortly after she recovered from the infection, an early trauma that was never disclosed, or all of these reasons.

In their book, *Reconceiving Schizophrenia*, Chung, Fulford and Graham define in a simplistic, yet insightful, way what someone who suffers with schizophrenia experiences mentally and emotionally. They write,

The victim of schizophrenia. This is a person who is subject to a diverse range of disturbances of perception, thought and cognition, emotion, motivation, and motor activity. It is a range in which episodes of dramatic disturbance are set against a background of chronic disability. The disability may consist of mild inability to cope with work or interpersonal relations, to profound inability to manage daily affairs and to care for oneself. Delusions of thought and cognition are a hallmark of schizophrenia. Perceptual hallucinations (including the subject's mistaking his or her own inner speech for voices), as well as disorders of emotion (including flattened affect), motor disorders, disorganized speech, and disjointed or weakened motivation, are elements of the disorder. (2011, p. 1)

This "sketch" of what someone who is unfortunate enough to be stricken with this elusive illness experiences is one of many interpretations or definitions of its symptoms. The Diagnostic and Statistical Manual of Mental Disorders, although historically controversial, has been one of the most widely used and recognized tool for classifying and diagnosing mental disorders since its first publication in 1952 by the American Psychiatric Association. Thousands of books have been written on schizophrenia from every scientific, medical, psychological, anthropological, evidence-based, and empirically supported

discipline. Yet, I found the firsthand accounts written by the sufferer, such as *Autobiography of a Schizophrenic Girl* by Marguerite Sechehaye (1951) and *I Never Promised You a Rose Garden* by Joanne Greenberg (1964), gave me much more understanding, insight, and compassion for the mentally ill. I have never forgotten these semi-autobiographical stories, unlike some of the scholarly texts I have read over the years.

I hope the following vignette is the spark that ignites a curiosity to learn and understand more about the phenomena of working with someone who suffers from schizophrenia and an empathetic treatment approach.

### **"Jean, I'd Like You to See a Young Lady Who Suffers From Schizophrenia": The Referral**

It was always a pleasure hearing from Dr. Norman Goldstein, the medical director of a local psychiatric hospital. Dr. Goldstein was my first boss in the field of mental health more than 30 years ago. We worked together in 1980, when Dr. Goldstein, a skilled and compassionate clinician, was one of the admitting psychiatrists and head of the admissions unit at the State Psychiatric Hospital and I was a psychiatric social worker.

In between his familiar greeting, and the nostalgia I felt whenever I was reminded of my early years in the mental health field, I sensed a hint of exhaustion mixed with some indecisiveness as Dr. Goldstein began to explain the reason for his call, "Hello Jean, Norm here. How are you?"

"I'm well, Norm," I answered. "How are you? As busy as ever?"

"Oy, the admissions never stop, and patients seem to be more symptomatic and requiring longer hospital stays," he said. "There is an alarming increase in the young adult admissions with co-occurring disorders, substance abuse mostly, but some with PTSD. It is almost impossible to determine what came first. Was it the trauma and the psychosis as a subtype of the PTSD, or had there been symptoms of schizophrenia prior to a trauma, which just compounded the positive psychotic symptoms? Our family therapists have been working overtime to collect the data and history needed to sort out some of these more complex cases. And the substance abuse! Oy, as we all know, it is at epidemic levels in all walks of life, not just among the mentally ill."

"Yes, it's more like a pandemic!" I agreed. "It sounds like you are going 24/7, Norm. What can I do for you?"

"Jean, the reason for my call is to discuss a referral," Norm continued. "I would like you to see a young lady who has been a patient here for the past six weeks. She suffers from schizophrenia. She came into the hospital quite ill. She was extremely paranoid, delusional, and experiencing both visual and auditory hallucinations. She believed she had the power to summon the dead, but not the ability to return them to their eternal resting state. She became obsessed trying to decipher who was dead and who was living, and how she could stop what she felt was the beginning of the end of the 'living world.' She had a healthy mix of positive and negative psychotic symptoms<sup>1</sup>. This was not her first hospitalization. It was, in fact, her fourth in the past seven years. It was her first time with us."

"How difficult it must be for her," I said. "I'm assuming she is stable now?"

"Yes, yes, Jean, she is stable and ready to go home," Norm replied. "I won't say she is completely paranoid free. She is still anxious, and has some fixed delusion regarding the medical field, me in particular. She feels I want to over-medicate her so she will remain here indefinitely and I can collect her SSI checks for my own personal use. But, she manages the delusion and it is correlated to her level of anxiety and vice versa. She needs to leave here; I think that will help diminish her anxiety."

"Well...Norm, thank you for the referral," I said. "I don't want to sound unappreciative, but why me? Wouldn't the partial hospitalization program, where she would receive more structured, daily services, be more appropriate?"

"Yes, the outpatient clinic would have been my initial suggestion, too," he agreed. "But Alice, that's her name if I haven't mentioned it already, and her family requested a private practitioner in the community. At our last family session two days ago, Alice expressed that she had never seen a therapist in private practice and would like the opportunity to try therapy with someone not connected to a 'hospital.' Her parents, who are very supportive and involved in the treatment process, strongly agreed. They shared with me that they would do anything to help their daughter and, if Alice was willing to see someone, which they said has rarely been the case because she usually refused any kind of psychotherapy, they would not deny her the experience. I could sense they are still hopeful she might recover. I will

continue to monitor Alice's medication at the clinic when she is discharged, unless she changes her mind. Can you see her? And when?"

I replied, "How about Tuesday at 10 a.m.?"

### **You Cured the Crazy Girl! You are a Healer of Psychos!: A Psychosocial History<sup>2</sup> of Our Therapeutic Dyad**

When Alice first started treatment with me she was 25 years old, and was diagnosed with paranoid schizophrenia at age 17. Since her initial diagnosis, she had multiple hospitalizations for psychosis with religious delusions, paranoid ideations, auditory and visual hallucinations, disorganized speech, and extreme agitated moods.

Alice was tall, maybe five foot ten, and weighed about 140 pounds. She looked much older than her years, most likely a consequence of the illness or the battle she fought against it. Numerous medications for schizophrenia, depression, and anxiety affected her flawless skin, and made it pale with gray tones. Her hair was very thin in some spots, where she pulled it out when stressed (Alice suffered from a form of trichotillomania). For such a dark shade of black, a color similar to onyx, her hair had a lustrous quality to it. She wore it long and straight, sometimes with a tie-dyed headband she made herself. Her hair was not always clean, nor was the headband, but the majority of times we met, Alice was neat and rarely disheveled. In fact, she was usually fashionably, but slightly eccentrically, dressed.

Alice had a way of putting together an outfit that was a work of art. She loved color and jewelry, and somehow coordinated a yellow t-shirt with lime green jeans. She wore multiple silver and gold chains around her long, slender neck, while matching bracelets with an array of tiny crystal sea creatures, birds, and beads she hand-painted in various colors dangling freely from their individual hooks hung loosely on her thin wrists. A pair of black hiking boots or purple high-top sneakers were her preferred footwear. An original headband, artistically yet modestly dyed or bedazzled, completed the haute couture. Atwood writes, "the journey of creativity is very often one that supports a person's sense of being real" (2012, p. 40). I made sure I complimented Alice's artistic gift of design, clothes, and jewelry when appropriate. She was quite talented, and shared that any form of artistic expression was an outlet, or rather an "inlet" for her. As she explained to me, "When I blend together colors with paint or clothes, or when I blend together words to create

a narrative of a time lost or a time found, or when I view the beauty or pain of others, I feel closer to who I really am and not a slave to the aberrant monster. I see art, whether I paint, read, or write, as a way to enter the world of sanity, an inlet to hope.”

On many occasions, Alice outlined her almond-shaped hazel eyes with dark makeup, which gave her the appearance of a gypsy from the eastern bloc of Europe even though she was of Irish and German descent. She didn't look like the kind of gypsy who tells fortunes of love, wealth, and future trips around the world, but rather the kind who puts a curse or hex of bad luck and heartbreak on an unsuspecting victim who the gypsy felt crossed her in some way.

Although her clothes screamed confidence and individualism, with an air of superiority that could be regarded as having no concern about how others with a lesser flair for fashion viewed her, Alice walked with a slight shuffle. She had little muscle tone, her shoulders somewhat hunched over, arms crossed in front of her chest, head tilted slightly to the left, eyes gazed downward, which could be interpreted as a person who was victimized or bullied in the past or present. Indeed, Alice was a victim of abuse. Her perpetrator, who made her a victim of mental madness, was a predator who devours mental and social wellness as prey, and leaves behind “torn souls” (Atwood). Her appearance created a visual contrast that it didn't quite startle you, but caused a feeling of uncertainty, and an emotional alertness to “proceed with caution.”

Over the two years we worked together, Alice shared as much of her life as her illness permitted. She usually unleashed experiences and information about herself, past and present, during one of her ranting rages, which could be triggered by what she felt was a personal attack on her because my office's parking lot was nearly full when she arrived. She was afraid she would leave my office and not locate her car (which she rarely drove to my office for fear she would run someone over in the “maze of mobile madness” she called the parking lot).

During Alice's moments of loose association, but mild disorganized thinking, I developed the skill to decipher the cryptic narrative hidden in her extravagant speeches, much like a forensic detective sorting through a chaos of clues and analyzing verbal evidence, about her life prior to and during the active phase(s) of the illness. I attempted to help Alice analyze the delusion, perceived fear, or internalized conflict that caused

her unbearable emotional pain. I gave merit to her fears and concerns, and interpreted the metaphors/delusions and symbols in hopes of minimizing or clarifying the nature of the psychoses.

On occasion, Alice experienced a breakthrough, and gained insight and control over a delusion. As a witness to her process, I validated, empathized, and gave meaning to what plagued her mind and soul. Most importantly, I listened to every word she expressed verbally and nonverbally, for there is no breakthrough if no one is present to confirm and witness the journey (Atwood). Atwood writes, “What a person in the grip of annihilation needs, above all else, is someone's understanding of the horror, which will include a human response assisting in the journey back to some sort of psychological survival” (2012, p. 45).

What emerged from the intersubjective dyad helped Alice find solutions to issues, and achieve periods of stabilization. Alice's ability to experience my empathy for her and her situation enabled her sense of security with our process, which was the prerequisite to when insight was gained and progress was made. Dr. Jason Throop writes,

I argue for the significance of recognizing that empathy is rarely an all or nothing affair. Nor is it necessary that it be based on some set of homologous experience shared between individuals. It is, instead, a process that is arrayed, intersubjectively constituted, and culturally patterned. Even in the face of mutual misunderstanding, possibilities still exist for moments of empathetic insight to arise. (2010, p. 771)

I agree with Throop's theory that empathy is a common bond between people, regardless of their differences. But because of Alice's unpredictable moods and psychotic episodes (most often correlated with her non-compliance in taking her medication as prescribed), there were times when Alice and I faced “mutual misunderstanding” that caused a detour in the therapeutic process. No matter how emphatically and clinically I approached her complaints, issues, or symptoms, she projected with a venomous bite to her words a soliloquy regarding what she was convinced were my unscrupulous motives to harm her. For example,

Jean, who the hell do you think you are talking to? And why are you trying so desperately to

get inside my head, my soul, my being where the truth lies in bed with the devil? You cannot penetrate my facade of aloofness with your scholarly words for sympathy. I know what you're doing. I can see through your veil of altruism, I can see your envy like the green monster of despair. No, not jealousy Jean, *despair*. Despair that you cannot heal the suffering, there is no hope for you! George MARYANN Elliott<sup>3</sup> who also hid behind a life of sin and sex! I KNOW WHAT YOU ARE DOING. YOU ARE TRYING TO STEAL WHAT IS LEFT OF MY BRAIN! WELL, FUCK YOU JEAN, I WILL REPORT YOU TO THE MEDICAL BOARD AND HAVE YOUR LICENSE TAKEN AWAY FOR CAUSING IRREVERSIBLE DAMAGE TO ME. YOU ARE A DANGER TO SELF AND OTHERS. YOU SHOULD BE LOCKED UP AND LIVE A LIFE OF LOVELESS AND SEXLESS SOLITUDE.

This segment of a session was a common occurrence during our first six months to one year of work together. Many times the sessions ended within 20 minutes or sooner, due to Alice's escalation of anxiety, fear, and ultimately, paranoia. Alice always felt an underlying anxiety. The times of mental stability, when she was not experiencing any covert symptoms such as paranoid, disorganized thinking, or delusions, might only last for three or four weeks. Then she became extremely anxious, paranoid, or depressed, and could not tolerate self-disclosing or the interpersonal relationship we were in the process of developing. She withdrew or became angry, claiming I put unnecessary and extreme pressure on her to be a "success" so I could "look good to all your therapist friends." With a sneer, she would yell, "You cured the crazy girl! You must be an exceptional psychotherapist, the healer of psychos. Your mother must be very proud, may she burn in hell along with the Virgin Mary and Mary Magdalene." Then quoted Revelations 20:10, "The devil, who deceived them, was cast into the lake of fire and brimstone where the beast and false prophet are. And they will be tormented day and night forever and ever."

Lysaker, Johannesen and Lysaker explain what could have triggered Alice's erratic behavior toward me. They note, "Interpersonal relationships can be so threatening that some persons with schizophrenia will actively disrupt meaningful relations in the interest of maintaining at least a minimal sense of self" (2005, p. 337).

To minimize Alice's fear of being "consumed" by me, I encouraged her to give feedback on how

she felt I was engaging with her, and reassured her that I respected her individuality and need for autonomy. More often than not, she gave me a dismissive wave of her hand and left my office. But she always returned the following week, and either picked up where we left off, or complained about an issue or concern with her psychiatrist or lack of friends.

During these emotionally reactive and delusionally driven sessions, I questioned my own sanity and ability to detach from the accusations. I got lost in my countertransference, and beat myself up for taking on a client who seemed impossible to treat and caused me to question my skills as a therapist. "A therapist working with schizophrenic patients will experience such unpleasant feelings that to avoid these feelings, the psychotherapist avoids the patients," write Karon and VandenBos (1994, p. 216).

To maintain progress in the therapeutic dyad, and reduce my feelings of countertransference, there were five issues that I addressed continuously during the therapeutic process.

First, it was imperative I stay cognizant of the fact that the client did not have a choice about being stricken with such a severe mental illness, and I needed to be respectful of the uniqueness of her disorder. Pienkos and Sass describe this as follows,

Schizophrenia does involve experiences that are quite radically outside the norm and failure to recognize this is likely to miss something important about the schizophrenic experience. Such an error would, in our view, be a particularly extreme version of the point to which Levinas calls our attention: namely, that there is always something beyond our understanding of others, and failure to appreciate this dimension of incomprehensibility or mystery is to miss something of the other's humanity. (2012, p. 31)

Second, I didn't consciously want to "miss" anything about Alice or the intense war she battled to stay connected to reality, but it was not always easy to remain objective. I, too, fought to remain patient and empathic. Sometimes I had to search hard for the right words to validate her tremendous and continuous struggle with the unfathomable fear she faced when she was psychotic. I cringed when she screamed at me that she was calling the police or FBI because she

thought I took her money and ID out of her pocketbook when she went to the ladies room.

To add to what Pienkos and Sass stated, Karon and VandenBos, in their book, *Psychotherapy of Schizophrenia*, give further suggestions to help diminish the countertransference feelings that occur when dealing with the rapid mood swings and dramatic behavioral changes of a client with schizophrenia, and to help the therapist feel less emotionally abused. They write,

The therapist will be puzzled and confused, and he must tolerate his own confusion. He will resonate to the patient's anger, depression, and fear. In all the problem areas of life in which the therapist has experienced difficulty, the patient is likely to have had even more, so the therapist will find himself having to confront those areas of life in which he is uncomfortable; however, the therapist will find that the patient's difficulty is many times greater than that of the therapist. (1994, p. 152)

Self-reflection, as Karon and VandenBos reference, was a necessary process for me, and was key to minimizing my countertransference issues. It was also a skill that did not come easily or quickly, or without help from an experienced clinical mentor.

Third, I did not want to replicate Alice's history with other mental health professionals and people in general. Alice had shared that a psychiatrist once told her that she suffered from "a disease of distorted perception," and that she did not know what was real and what was a delusion. Because some friends, family, and even mental health workers had abandoned her since the illness manifested because it frightened them, or she was too much trouble to deal with, Alice believed she had done something horrible that she was unaware of, and that it happened when she was being controlled by Satan. Alice was so frightened that this was the reality – that Satan's control of her was why people rejected her and wanted to hurt her – she sometimes lived in a dissociative state for months – afraid to come out, afraid to let anyone in.

Alice never participated in ongoing psychotherapy with any clinician before me. Except for the many psychiatrists she saw over the years, primarily for medication monitoring and the day treatment or partial hospitalization programs she attended after each inpatient psychiatric hospitalization for a few months to

one year, she felt no one would or could help her. The second time we met, she said with a flat affect, "I have an illness that severed my emotional connection to a period of existence that I can barely remember, a time when I was without fear and anxiety. It was the time I lived prior to being damned with this mind-manipulating malady called schizophrenia."

Fourth, I had to have patience, and, at times, just be a witness to Alice's pain and suffering. Alice's behavior and pathological fear of allowing herself to engage with me delayed and interfered with the development of the intersubjective dyad. These were difficult sessions, and I often had to remind myself that I was doing more than "merely treating symptoms, but engaging with fellow human beings" (Pienkos and Sass, 2012, p. 25). But Alice was a fellow human being who could become extremely angry from one minute to the next, or psychotic because of intolerable levels of stress or conflict that were not always measurable or predictable. Sometimes it took weeks after one of her dissociative derailments for Alice to settle back into a comfortable rhythm of sharing one of her four primary concerns: issues with taking her medication and believing that the psychiatrist was over-medicating her, going back to school, seeking employment, or her overwhelming fear of when the next psychotic episode might occur. Alice described the feeling associated with her decompensating into psychosis as "the leech-like tentacles that grab you from the deep place where the sun is silent<sup>4</sup> and suck the sanity and life out of you at the same time."

Fifth, I realized that I had to let go of "fixing" what I believed Alice needed repaired, and be more empathic to her tenacious fight to be heard and not misperceived, to be accepted and not rejected. Strengthening the intersubjective dyad required empathic attunement. I needed the insight and ability to let go of the negative emotions, and self-reflect in order for Alice to gain any kind of insight or progress, whether momentary or permanent. In their article, *Empathy in Psychoanalytic Theory and Practice* (2011, p. 10), Grant and Harari discuss a session with a female client identified as H,

My empathic attunement was operating more at the emotional contagion/mirror neuron level. Without really understanding why, I realized that H needed me to be there, saying nothing or very little, but as an object or other in relation to whom she could express (by moaning, writhing, grunting, and screaming)

subjective self experiences that ordinary relationships could not tolerate without the other fleeing or trying to calm, either of which just created high levels of frustration for her.

I debated and battled with my thoughts and feelings regarding the ethical and therapeutic benefits of continuing therapy with Alice, who was more delusional and dissociative than not. Even though I was determined not to give up, it was hard not to question why I would go on. And why would she? I wondered if there could be change, or at least help to prevent her from returning to an inpatient setting. I did not want to abandon or reject her because of the difficult symptoms, but I could not clearly see the value of the treatment. I fantasized about ending treatment and referring Alice to someone else. But I processed my emotions, usually with the help of my clinical mentor. When the fear and flight feelings subsided, and I would self reflect, I was able to again be objective just in time for our next session.

I believe the times Alice felt she was being understood and validated that she was not “crazy” but suffering from symptoms that could be terrifying and uncontrollable helped her feel safe, and, on occasion, able to explain in detail, with the accuracy and confidence of a great historian, the progression of her psychotic episodes. The first time was during our eighth session, when Alice shared the details of her first psychotic episode and decompensation into madness. It validated that Alice felt safe enough to trust me with the information. But I also recognized that it could be the only time she would feel the connection, and allow herself to be vulnerable and engaged. Fortunately, that was not the case.

**“The End of Me”: A Recount of Alice’s  
Prodromal and First Active Phase of  
Schizophrenia<sup>5</sup>**

During our eighth session, Alice shared that she remembered waking up one day the summer before her senior year of high school, when she was 17 years old, and felt that there had been a shift in her. She thought that her perception of the things around her—her room, parents, friends, even how she felt physically and emotionally—was more developed, not in a positive, insightful, gifted way, but in a precautionary, solitary, uneasy way. Alice described how her thoughts darted from one idea to the next, making it difficult to stay focused and in the moment. She often lost track of time. Hours went by, and she had no

explanation for what had occurred or why time eluded her. Some days, a mental, but also physical, fog swallowed her whole. It paralyzed her thoughts and behavior if she did not fight with all her strength to control it, or at least minimize the effects.

Alice believed she tried to tell her grandmother what was happening to her, but couldn’t find the right words to be understood. She also had an overwhelming sense of fear that she would share something that was meant to stay hidden. She believed she belonged to an esoteric society, and what she experienced needed to remain confidential or she would suffer an unimaginable consequence for breaking the rules. She repeated the words that ran through her mind during this time, “I knew it was the end of me.”

Alice described herself as a semi-popular girl in high school – not in a happy cheerleader kind of way, but in a cool, bohemian artist way. She said, “I was quiet, you know, a girl of few words. I had the same small group of friends since parochial grammar school, and made a few more good friends in public high school. But I was also very OK with doing my own thing, being alone.”

She continued the timeline of her first psychotic break and stated that some time around October of her senior year she developed a strong, sometimes overpowering urge – “an impelling force” – to save the underdog. This “call to action” behavior puzzled her because she did not consider herself to be very empathic, compassionate, or a crusader like Joan of Arc. (Years later, during a psychotic episode, Alice believed she was the reincarnation of Joan of Arc, and that it was her divine guided mission to lead the French into England and “de-throne” Prime Minister Margaret Thatcher.)

She said, “I could not control the impulse to lash out, to yell at the jock predators or at the vice principal in charge of disciplining the rule breakers. I believed the vice principal was trying to sabotage me, and stop me from graduating because he was jealous of my ability to control students’ thoughts. I had these cursing outbursts, not directed at anyone in particular, while walking to my classes, then quickly retreated back to the comfort of my introversion. I preferred to walk to class alone. I looked down at the hallway floor to reduce the chance of making eye contact with someone who might be eager to discuss the latest Chemistry homework assignment, or want to get together over the weekend to party, or go to the dreaded mall. If I walked with my head up and eyes looking straight ahead, I purposely avoided

connecting with anyone for fear they might potentially sabotage my space. I looked past them, or even through them, as if they were made of glass. If someone called my name, or said hello, I ignored the greeting, pretending I didn't hear it. I also didn't know if I heard correctly, because I had so much constant chatter and noise going on in my head. I couldn't tell what was inside my head or coming from the outside in. I believed I could control thoughts and receive thoughts from others.

"My parents saw the change in my behavior," Alice continued. "I started to withdraw socially, and isolate myself from them and my friends. I was irritable and angry. I started to think people were plotting against me, that the other students sensed I was a threat to them because I knew their deepest, darkest secrets, which teachers they were having sex with, and which teachers were pedophiles.

"By December, I constantly heard voices, predominantly a female voice telling me to kill myself by crucifixion on Christmas day," she said. "This command was unceasing, as was the belief that my parents and grandparents were part of a devil-worshipping cult that wanted to sacrifice me to Satan. My parents took me to see a psychiatrist when I refused to eat any food that they prepared for fear they were trying to poison me."

That first psychiatrist diagnosed Alice as having a psychotic episode with auditory hallucinations and paranoia. He prescribed medication and referred her to a psychologist for therapy. A few days after Alice's visit with the psychiatrist, she grew even more paranoid and incoherent. She refused to take the medication, and began to suspect that the psychiatrist had removed part of her brain while she was pacing in his waiting room, unable to sit due to her severe agitation.

Alice's pathological fear of certain mental health professionals seemed to be connected to that first psychiatrist. Her bizarre delusion about this doctor periodically surfaced throughout the years. There were times when she was so consumed by thoughts of his "evil and unprofessional behavior for a doctor" that she stopped eating, sleeping, and performing basic hygiene, or wouldn't leave her bedroom for days. These episodes were usually accompanied by auditory hallucinations, in a male voice. Alice was convinced it was the doctor laughing at her in a sinister way, and threatening to tell her current psychiatrist to lock her up and throw away the key because she was a "half-wit," a "freak with only a fraction of a brain" and "a danger to self and

others" with no ability to "comprehend" right from wrong because she was a parietal lobe-plegic.

Alice's first psychiatric hospitalization was in the local community hospital. She was hospitalized for six weeks, until it was decided she was stable on her medication and could be treated on an outpatient basis. This was the first of Alice's numerous hospitalizations, outpatient treatment programs, and therapist and medication management. Over the course of her illness, her hospital stays ranged from one week to four weeks, depending on the severity of the symptom(s). When Alice experienced a non-bizarre fixed delusion, but her speech was disorganized and incoherent with a flat affect, her psychiatric in-patient treatment might be one week for medication stabilization. But, when Alice was combative, physically violent toward others, hitting and spitting brought on by the multiple voices in her head – running commentary on her worthlessness, along with extreme paranoia of people, especially those in the mental health profession – she remained in the hospital longer to stabilize.

Each hospitalization seemed to be worse than the previous one. And after each discharge, Alice became less hopeful that she would improve and lead a life where she could hold a job, have a few friends, get married, or live on her own without family or case worker supervision. Her hopes and dreams were basic, simple, and attainable by most people. But for Alice, and other men and women who have life-paralyzing psychosis or depression, these goals can be as impossible as comprehending the size of the universe.

### **"Have We Failed Her as Parents?": A Family History**

To gather family history, and assess the family dynamics and any pathology of the parents, which may or may not have played a role in Alice's disorder, I asked her family in for a few sessions. I learned that Alice lived with her parents and maternal grandparents. Her parents were middle school teachers, and her grandparents ran a small luncheonette in the town where Alice was born and raised. She was an only child, as was her mother, and the only grandchild. She was loved and cared for by these four adults. They were very religious, and claimed to be "born again" Roman Catholics who looked to Jesus Christ for salvation, similar to the Evangelical Protestants. This orthodox religious upbringing had an obvious

influence on Alice – the majority of her grandiose delusions were religiously based.

Alice had four aunts and two uncles on her father's side of the family; her father's parents died before Alice was born. Both her paternal grandparents and twin uncles suffered from schizophrenia and depression. All four were hospitalized for years in the state psychiatric hospital. Her uncles, who both had long-term hospitalizations from age 24 to about age 30, were discharged after five years of hospitalization because of advances in medication to manage psychotic episodes, the laws regarding deinstitutionalization, the availability of community- mental health centers, and the Federal Social Security Income for the mentally disabled. They were in their 40s, and lived in a boarding home. Family rarely visited. Alice's paternal grandparents were never able to achieve mental stabilization in order to be discharged from the hospital. They both died in the state hospital, two years apart, in their mid-70s.

As a result of meeting with Alice's parents, I discerned that they were dedicated to helping their daughter, who could never outwardly reciprocate their love. Alice didn't allow them, or anyone for that matter, to get too close to her physically. She reacted violently, screaming that the invader of her space was trying to take control of her body, to snatch it away and leave her devoid of a physical self. During the times I talked with Alice's parents, they never complained about their situation or the limited emotional and mental connection with Alice. They searched constantly for help for her, and to understand what they did wrong. Parents of a child of any age who suffers from schizophrenia need support and some form of therapeutic intervention, such as group therapy or self help with other parents of the mentally ill. They can suffer from intense feelings of guilt, shame, anger, fear, and powerlessness.

At one family session, Alice's parents shared that they were so desperate for answers as to why their only child was stricken with such a mentally fatal illness that they consulted a "spiritual medical psychic" in hopes of finding the "reason" she was not spared from the madness. Alice was 21 at the time. The "psychic" gave them a homeopathic remedy to replace Alice's antipsychotic medication, and a prayer ritual to perform in order to lessen the psychotic episodes, and give her some much-needed peace from the torture. There was no positive outcome from their meeting with the self-proclaimed psychic healer, except for the few weeks they allowed themselves

to believe that it might work. This gave her parents only a short (phantom) reprieve from their feelings of hopelessness and powerlessness, but unfortunately the encounter escalated Alice's anxiety and fear. Her parents reported that she became obsessed with thoughts that the "spiritual life coach" performed a satanic marriage ceremony, and Alice was the earthbound bride of Satan who, at any moment, would be summoned to hell where she would burn eternally in the fire of Satan's sadomasochistic love. She decompensated one month after the visit with the bogus emotional manipulator, and was hospitalized for the second time.

Alice's parents described her interactions with them as a mixture of hostility and compliance. They shared with me their feelings of guilt and anxiety, and did not consider themselves to be "victims" of their daughter's acting out, or at times threatening behavior, as some living with a sufferer of schizophrenia would. They said, "Jean, we have gone to many therapists, psychiatrists, hospitals, and prayer groups. We tried many medications, and even got on a list for a clinical trial for a new medication but Alice refused to participate. She thought we were going to leave her at the hospital, where they would physically rewire her brain. So far nothing has helped long term. Is it us? Have we failed her as parents? What did we miss when she was growing up?"

I have been asked these questions many times, and I always answer them in a similar way: "I don't know what caused your daughter's symptoms, and I'm not sure if anyone can say exactly what the cause is or was. There might never have been any warning signs or early symptoms that you could have done anything about. Being a parent is a difficult job, and when you have a child with emotional problems, it is even more difficult. I hope I can help. What do you think is, or was, a factor or factors in your daughter's decompensation?"

According to Alice's parents, she had a normal childhood. They shared that she was always anxious about starting something new such as school or a play date, and she was shy. But she loved to play with her dolls, and entertaining herself was never a problem. They stated that they did not have any concerns regarding her mental health or any issue until her senior of high school.

Alice's parents described some of the few precious times Alice was stable and able to engage with the family after she was diagnosed. She cooked with them, played cards and board games, and visited museums and art galleries, which was

one of Alice's favorite pastimes. They smiled when they shared that she had a great sense of humor, and was very witty when she felt comfortable and not stressed.

I met with Alice's parents a few times over the course of her treatment, but I referred them to another practitioner for their own work. I never lost sight of their struggle and the love they had for their daughter. As Karon and VandenBos remind us,

The parents are engaged in a struggle, to live with and provide for a very sick, puzzling, and difficult child. The treatment of the child often means intense personal and psychological discomfort for the parents, because it means changing techniques of adaptation that have worked for them; yet parents will go to extraordinary lengths to see that their child gets help, and to do what has to be done for the child's best interest. (1994, p. 113)

Not all parents of the mentally ill are willing or able to participate in their child's treatment as Alice's parents did. Minimum family participation, along with medication compliance prescribed by a psychiatrist, and participation in a self-help group, if appropriate, are requirements for working with me. Under certain circumstances, these requirements may be modified.

### **Alice in the Shattered Looking Glass: Segments From Two Different Therapy Sessions That Illustrate How Alice's Illness Manifested**

#### **Segment 1**

Alice shared her passion for art with me during one of her more cognitively clear, but emotionally charged sessions during the sixth month we worked together. She mocked the choice of art in my office waiting room one day, claiming, "Anyone who would display cheap Monet prints most likely had cataracts too." When I asked Alice what she meant by her Monet comment and reference to cataracts<sup>6</sup> she laughed in a sinister way and told me with pressured speech, "Monet could not see that although Mary Cassatt's art did not have the same savage quality as his, she was a contemporary no less!"

Alice explained desperately, as if her life depended on me understanding her point, how she would get lost in American impressionist artist Mary Cassatt's painting, *The Child in a Straw Hat* (1886). Alice believed the painting captured

the moment right before the terrifying entity of mental illness, schizophrenia, abducted Alice both mentally and emotionally. "It was me in that painting," Alice said. "I saw as if I was looking in a mirror how I was right before I fell into hell and shattered like glass into one million pieces."

Alice said that after she first viewed the painting at the Whitney Museum in New York City while on a field trip with a group of psychiatric patients from the out-patient program she attended five days a week after her second hospitalization. She had just turned 22. After that trip, Alice wore a similar style straw hat as the girl in the painting when she felt herself begin to lose the "feeling of her surroundings," when her sense of touch, sight, and balance eluded her before she decompensated into psychosis. She described it to me loudly and angrily: "I could no longer smell the coffee brewing in the morning, or the wet dog when she came into the house after sitting in the rain for hours waiting for me to come home. But, what scared me most was when I could no longer gauge whether I was standing or sitting. I constantly went from one position to the next, no matter where I was. I could be on the subway, in a doctor's office, at home at the dinner table, or at the movies, and I could not 'feel' if my legs, my butt, or my back were in the right position. So I went from sitting to standing every 30 seconds or so for hours, sometimes an entire day, until I fell into a deep sleep. This went on for days, even weeks.

"I also saw the world and everything in it not in three-dimensional, but in one dimension only," she continued. "Everything was flat and lacked color, only gray and off-white were visible. I believed that wearing the straw hat would stop my mind from deceiving me, or postpone the voices that inevitably followed this experience. They taunted me, told me I was sick, demented, and worst of all, a mistake. I thought the hat protected me from the warped word war going on in my head. I remember pulling the hat farther and farther down over my forehead, then my eyebrows, until it eventually covered my eyes completely. Yet I kept it on until I ended up in a hospital or at my psychiatrist, who talked me into taking medication to alleviate the symptoms of the psychotic episode.

"I used that straw hat for three or four years to help me fight off the beast of destruction," she said. "I'm not sure if it really helped or not. I'm not sure it didn't have magical powers. I can't 100 percent say it didn't help in some way. I remember feeling somewhat safe when I first put it on, like a friend

was standing by me. That feeling didn't last long. I still got sick. The hat is battered and worn out, but I still have it hidden in my room. You never know when you might need a friend.

"My parents hated that hat, I think because it represented to them that I was *decompensating*. They had post-traumatic anxiety attacks when they saw me wearing it. My mother lost the color in her face, and asked me how I was feeling and if I was taking my medication as prescribed. Then she started to pray to herself. My father usually ignored the hat, tried to deny it was the start of something, until he saw it was covering my eyes. Then he took me to the psychiatrist."

At this point Alice abruptly stopped talking, left my office, and paced in the outside hallway for 10 minutes, mumbling to herself. This was a common occurrence whenever Alice felt a combination of emotions that she could not tolerate or differentiate. The feelings of frustration, happiness, fear, and anger were overwhelming and a trigger to dissociate when experienced simultaneously. She was frustrated at her inability to communicate her thoughts and feelings appropriately at times, and happy when thinking about and discussing her love of art. She feared her illness would take this passion away, and was possibly angry with me for not making her better.

I purposely didn't interrupt Alice's monologue because I was hopeful, but not convinced, that being there for her might be all she needed. It was initially difficult to accept that a traditional psychotherapy approach was less effective than just being a "good listener." Atwood writes, "Often the simple presence of another human being who is actually listening to the story that is being told is all that is required" (2012, p. 51). But it was a challenge for me to determine when to just listen and when to interject a question, interpret a delusion or ruminating thought, or even assure Alice I understood her feelings or validate her. Because her moods were unpredictable, and she grossly overreacted to a word, phrase, question, or the way I moved my head when speaking to her, which could set off a barrage of accusations regarding some devious motive I had for treating her, or jealousy of her high IQ and my mission to destroy her brain by ECT therapy, I carefully assessed my feedback before I gave it, and always communicated to Alice as an equal.

Some people in the general public, and even some in the mental health field, have treated the psychiatrically ill as if they are of lower IQ, have no ability for insight, are violent, have no feelings, or want to be delusional or manic. Throughout

history, there has been a tendency to treat the severely ill as if they were lesser quality human beings and either ignore them, warehouse them in jails or unacceptable living situations, or act with great impatience toward them.

Marguerite Sechehaye suggests that the "observer" of the schizophrenic be mindful not to assume or judge based on behavior and simultaneously opposing verbal content that the patient is not introspective or is "gravely ill." She writes:

It is always amazing to discover that the patient who seems demented is actually clear and aware of what goes on about him. There is then a tendency to blame him for his symptoms as though he could control them, forgetting that he is indeed truly powerless and irresponsible. (1951, p. 17)

## Segment 2

I believed Alice felt I was less a threat to her as time went on, so I was a bit surprised when, about a year into our working together, she shared with me that there were times she was afraid to let me know how she was feeling because of what I might do. She said she sometimes feared she might disclose a random thought about killing herself, or how she believed Mother Teresa was trying to send messages to her about redemption. She was convinced that Mother Teresa wanted her to minister to the prostitutes on 9th Avenue in New York City. This message, she believed, was sent telepathically to her via the Pakistani attendant at the neighborhood gas station she visited daily. Alice parked at the gas station for 20 minutes each day, whether she needed gas or not, in hopes of putting an end to Mother Teresa's religious espionage by showing the attendant (who Alice referred to as Cerberus, the Pakistani guard dog of the gates of hell) that she was in control of her thoughts and behavior. She was not going to allow the mind-control tactics that he and Mother Teresa were attempting to use on her to penetrate her head and affect her "sanity thoughts" (what Alice called her thinking when it was not disorganized, fragmented, and becoming psychotic).

She was afraid I would misinterpret her concerns, or ruminating thoughts she experienced, and feel she needed hospitalization. So she kept them to herself, which eventually caused her great anxiety. This escalation of anxiety was eventually treated with either an increase in medication to

help reduce the anxiety, which usually was an indication that a psychotic episode could follow, or she fixated for several sessions on the lack of global concern over the use of saccharin in food and its link to cancer and schizophrenia. I told her how grateful I was she felt ready to share with me her fears regarding hospitalization, and how sorry I was she needed to keep it from me because she was afraid.

### **“I Would Be an Exorcist!”: Identifying Alice’s Goals**

I had a preconceived treatment plan for Alice, and was frustrated she wouldn’t discuss it with me. So before I decided to throw in the “treatment termination” towel, I asked Alice for her feedback. The following narrative is an excerpt of that interaction:

“Alice, we have been meeting weekly for one month now,” I said. “I hoped we could spend some time today discussing if you feel the therapy is helping or not helping, if we need to change anything, and identify some of your therapy goals.”

“Do you mean change for me, for you, or for the insidious we?” Alice replied. “Change the feeling of the voice that surrounds me and alters my ability to think of other things without intrusion? Or change how you look puzzled, with tightness in your shoulders, when our time is running out and you are uncertain if you should end the session on time or run over by a few minutes because there might be a breakthrough? Or we, therapist and patient... oh sorry, you say ‘client’... and the ever-so-gradual development, well established before it is apparent unit, that could possibly affect and entrap a ghost? I have been ghosted! Someone or something else is manipulating my life. Is that the ‘change’ question you want an answer to? Have I answered it conspicuously enough for you?”

“What I believe you are saying is that a relationship takes time to develop before one feels safe and trusting, and ready to tackle a life-altering issue, a fear,” I replied. “And, that I need to be more relaxed about how the therapy is working and you need to...”

“Feel real,” Alice interrupted.

“OK, yes. You want to, need to, feel real,” I answered. “Can you tell me what that feels like for you? How would you describe that feeling? How would you know you are feeling real?”

“I would not be invisible to others,” Alice said. “I would have friends, marriage, maybe a child. I would work, maybe be a therapist or an exorcist. What’s the difference? Both are able to cast out

the devil, to rid people of the demons that keep them bound with shame and guilt, which causes horrific self-destructive behavior and thoughts. I would be an EXORCIST! And some day I will heal myself! Free of hospitals and witch doctors that profit from over-medicating and who do not speak my language of pain or understand my anguish. What can you do for me, therapist?”

“I hope I can help you with exploring and possibly meeting your goals. But I can offer you understanding, and that is for sure,” I said.

“Should we schedule now for next week, Jean?” Alice asked.

“Yes, we can schedule now,” I replied. “But I would like to finish by thanking you for the input and feedback. It is beneficial to me to know that this therapy is helping. Tell me if I am off base, but it sounds like you are feeling comfortable working with me, and would like to address issues that have caused you some shame and guilt?”

“That is close enough. Our time is over now, Jean,” Alice said.

### **“Why, Why, Why, Jean?”: My Phenomenological Experience With Alice**

I met Alice in the waiting room. She stood, and walked back to my office for our customary Tuesday at 10 a.m. psychotherapy session. Four steps forward and 10 steps backward was how I thought of our sessions. But on that day, I had a vague premonition that this session was going to be different. I attributed that feeling to my clinical intuition. We had been working together for a year and a half. Alice never missed an appointment, but rarely stayed for the full fifty minutes. She had begun to tell me when she was ready to end the session instead of abruptly or angrily walking out in the middle of a question or conversation, yelling over her shoulder as she exited the office, “Lighten up Jean, with your *need* to process every action and reaction, every word spoken, and read in my mind! It is going to be the end of you, or at least this session.”

As we walked into my office, I noticed that Alice had in her hand one of the assorted brochures that were on display in the waiting room. It was unusual for her to read anything while waiting for our session due to her chronic high level of anxiety. But, what caused me to be even more curious about this uncharacteristic behavior was the brochure she picked up. Alice had it tightly folded in half, and cupped between her hands as if she was hiding it from me for fear I would scold her for removing it from the waiting

room. The title of the brochure was *The Dangers of Hallucinogens*.<sup>8</sup>

Alice took her familiar seat on the far corner of the couch, diagonally across from the rocker armchair I usually sat in. I felt her watch me intensely and with impatient trepidation as I shut the office door and joined her in my office's pseudo-living room setting, which was designed to foster a safe and comfortable environment for emotional healing. Alice began the session with a question, which was not part of her therapeutic ritual. Normally, I began the session with some common courtesy or social etiquette statement such as, "how are you?" She would answer with an adjective that had little to do with how she was actually feeling, or spit the question back at me. She immediately followed with a verbal stream of consciousness related to the injustice or indignation of our society, and its neglect or laissez-faire attitude toward the genocide of the golden lion tamarin monkey in the Brazilian rain forest.

But on this day, Alice asked a question—calmly and articulately—which caused me to feel encouraged and uneasy at the same time. She held up the *Hallucinogens* brochure she discreetly kept tucked in her hand until that moment, and with a naive, childlike quality about her that she had never presented before, asked, "Can you explain what happens to people when they are under the influence of a hallucinogen?"<sup>9</sup>

Her question took my breath away for a few seconds. Never before in the year and a half we worked together had Alice asked me a question with not any inflection in her voice or without proceeding tentatively as if she was fearful I might react in an aggressive or dismissive manner. The question was presented in such a benign yet mildly eager way that I felt an expression of shock and enjoyment appeared on my face. I thought, "What is going here?"

And it wasn't just Alice's verbal presentation that changed, I saw her physically transform before me. For one fleeting moment, Alice became an inquisitive, attentive, young girl with a hint of intensity. She looked at me when she spoke, and I saw in her eyes a spark, like she was connecting to her inner driving force. She did not have the chronic tightness in her jaw, which I assumed was a side effect of her medication, and her brow was not lined with its usual creases, especially the two vertical lines between her eyebrows that reminded me of a pair of parentheses. Her skin had a very light shade, with a hint of pink to her cheeks, and her voice was steady and calm as she

asked what I initially believed was a very peculiar question. Alice experimented briefly with marijuana in high school. She never tried any other substance, including alcohol, because she was fearful of "losing control of her ability to reason," she once told me. She claimed she had never been interested in altering her "mood or mind" like her friends, which was one reason why I was so surprised by her interest in that brochure. I felt a rush of excitement that I was witnessing Alice before she became the victim of a negative energy that stole her mind and changed her forever. It was like seeing a rare bird – tremendous exhilaration at first sight, then a growing feeling of anxiety that any sudden movement, even an exhale, could cause the feathered treasure to take flight, never to be seen again.

A dichotomy of emotions bubbled up inside me. I felt special, like I was given a gift that was unique. I experienced for the first time what seemed like a symptom-free Alice. At the same time, I felt that I was privy to something accidentally, and there would be a consequence for that mistake.

I responded slowly, "Well, Alice, hallucinogens are classified into three categories: psychedelics, dissociatives, and deliriants. These drugs cause changes in a person's perception, thoughts, emotions, and consciousness. The psychedelic drugs—LSD, psilocybin, and mescaline—affect the sensory perceptions, causing everyday objects to seem more real or alive, and significantly changing colors, shapes, textures, and dimensions."

Alice cautiously, yet respectfully, interrupted what was turning into a boring didactic lecture on my part, and asked if she could read aloud a paragraph or two from the brochure. Her request to read to me was so unexpected, and so untypical of any of our previous interactions, that it took me a few seconds to answer. I prayed that my reaction wasn't obvious. I feared that Alice would feel that my split-second delay in responding was because I didn't want to hear her read. I grew nervous that she viewed my hairline hesitation as a rejection or mockery, which was far from how I really felt. I felt like I was engaging with someone I had never met before. I was mesmerized by this close encounter with an Alice who seemed to be momentarily free from the brain-beating, mind-melting, and soul-snatching condition clinically called schizophrenia.

I experienced a phenomenon that had no predictable end, but I knew that its end was inevitable. It was illusive, opaque, and seemingly timeless. I did not want it to stop. I hoped that this

cognitively and emotionally fragile woman did not misinterpret my mildly enthusiastic, “Yes, please do.” But I deliberately minimized my affirmation to her serious and uncharacteristic request because I was blinded by her determination to break free from the emotional chains that bound her mind, her spirit, and her ability to feel safe in a relationship. In my excitement that she was “trusting” and “connecting” with me, I felt a flash of vulnerability. I became uncertain about the interaction; one could interpret my reaction as “guarded.” I instinctively prepared myself for her usual barrage of paranoid ideations that encapsulated me and Alice’s 70-year-old neighbor in a conspiracy to steal her clothes while she was in my waiting room for an appointment I tricked her into scheduling.

But, Alice’s response was neither anger, aggression, nor regression in behavior (which happened often as a result of her misperception of our interactions. She would feel so threatened that she paced, muttered, and even hit herself in the head with her fist).

She began to read aloud from the brochure: “Depth perception is often heightened and perspective distorted; inanimate objects take on expressions, and synesthesia (hearing colors, seeing sounds, etc.) is common. Time may seem to slow down enormously as more and more passing events claim the attention, or it may stop entirely, giving place to an eternal present” (2013, p. 2).

Alice’s voice was audible and steady; she pronounced the words clearly, in distinct syllables. She was intelligent, with an uncanny command of the English language. During her most psychotic episodes, Alice’s ability to lash out with words – to attack and defend against the frightening and constant hallucinations and delusions that plagued her mind daily – was astonishing.

Alice paused for a few moments. A slight look of bewilderment crossed her face, yet her eyes remained fixed on the brochure as she continued to read, “The emotional effects are even more profound than the perceptual ones. The drug taker becomes unusually sensitive to faces, gestures, and small changes in the environment. As everything in the field of consciousness assumes unusual importance, feelings become magnified: love, gratitude, joy, sympathy, lust...” (2013, p. 2)

At this point in the paragraph, Alice swallowed hard, as if she was desperately trying to push down a rising eruption of emotion that would cause her to lose the delicate hold she had on her self-control. I could tell from her body language that she wanted more than anything to complete

this overwhelming task of reading the brochure to me. She moved to the edge of the couch, her back straight and stiff. Her hands gripped the brochure like a vise.

Somewhere deep within the catacombs of her mind, among the ruminating thoughts about killing herself, the paralyzing fear of being hurt by others, the screaming and satanic voices telling her she is no good, and the painful belief that what she perceived about herself and the world is the substantiated truth lies the Alice who, from birth to age 17, lived a normal and loving life.

Could this be true? Did Alice have a time when she was without incidence or symptoms of a mental disorder? Or was it my innate need to believe that Alice was once happy and unaware of the impending torture she would live with beginning in adolescence, rarely having any freedom from the illness’ debilitating symptoms? I wanted more than a glimpse into the health of Alice’s mind. I grew angry that I could not stop time, and preserve the phenomenon that was taking place in my office. I was bearing witness to what seemed like a fight between hope and the absence of hope.

I had never seen Alice work so hard at staying focused and present as when she continued to read the words that seemed to be choking her: “Pain, terror, despair, or loneliness may become overwhelming, or two seemingly incompatible feelings may be experienced at once. It is possible to feel either unusual openness or closeness to others, or exaggerated distance that makes them seem like grotesque puppets or robots. The extraordinary sensations and feelings may bring on fear of losing control, paranoia, and panic” (2013, p. 2).

She stared in my direction at the end of the last sentence, but she didn’t look at me. She seemed to have removed herself from the room. I had seen this trance stance many times before, but it felt different this time. I was concerned that Alice was beginning to decompensate, that perhaps this unfamiliar exchange between us caused her to feel vulnerable and stressed. Her defense when faced with trauma, or even a perceived trauma, had been to dissociate. Alice would become void of any emotional response. She entered into a state of trance and stayed there, sometimes for several minutes. When she regained her capability to respond verbally, she would be preoccupied and unable to continue the session. But during this session, Alice wasn’t dissociating. She didn’t feel threatened or experience a flashback as I had thought. I could tell by the determined look on her

face that she was contemplating. She was processing the information she read.

Because of the almost daily deluge of psychotic thoughts, and uncontrollable paranoia that was one of the primary symptoms Alice was afflicted with, I was concerned that she might slip into a state where she felt consumed by the terror of being exposed to harm, most likely the harm of losing herself. Although I was elated by the possibility that Alice and I were engaging in something that was not associated with her symptoms of a psychotic disorder, I knew to contain my enthusiasm for fear I would frighten her with my outward expression of emotion. My primary concerns were her emotional safety, and respecting the boundaries of our therapeutic relationship – especially with her distorted perceptions, which were a reaction to her fear of being harmed mentally, physically, and/or emotionally. Atwood explains this fear as a phenomenon. He writes,

Phenomenologically, going mad is a matter of the fragmentation of the soul, of a fall into nonbeing, of becoming subject to a sense of erasure and annihilation. The fall into abyss of madness, when it occurs, is felt as something infinite and eternal. One falls away, limitlessly, from being itself, into utter nonbeing.” (2012, p. 40)

But, Alice wasn't falling into the abyss of madness as Atwood describes. She seemed to be engrossed in connecting with and conceptualizing what was written in the brochure, and what it triggered for her cognitively.

I thought she was about to ask a question, or share what she was processing, but she did not. Instead, Alice read more. At this point, I saw a change in her demeanor. There was a slight air of irritation about her. Her face grew tense as she read about the dissociative classification of hallucinogens such as MDMA: “The main difference between dissociatives psychedelics and serotonergic hallucinogens are that the dissociatives cause more intense derealization and depersonalization. For example, ketamine produces sensations of being disconnected from one's body and that the surrounding environment is unreal, as well as perceptual alterations seen with other psychedelics” (2013, p. 6).

Alice could no longer contain or control the outburst of emotions that practically suffocated her. She stood up from the cozy corner edge of the worn leather couch with a burst of energy I had

seen only when she was angry at what she believed was my lack of insight and sanctimonious indifference about her dilemma with the FBI and cable television. Alice raised her hands as if she was about to conduct an orchestra with the power of Bia, the Greek Goddess of Force. With her head back, her face looking upward, she screamed: “Why? Why? Why?” She then stared at me, with tremendous pain on her pale face, her head tilted in a way that stretched her neck and made her look more like a circus contortionist than my client. She asked, “Why, Jean, would anyone of sound mind and body, who had a mind that was quiet and clutter-free, and had never experienced depression or been admitted to a psychiatric hospital against their will... why would they voluntarily ingest something that would mimic all the signs and symptoms of the devil?”<sup>7</sup>

Although there were no tears in her eyes, Alice was weeping. Her sadness was mixed with disbelief; a groan escaped from deep inside her. She was grieving the loss of her sanity and the injustice of it all. When we first met, Alice shared how angry she was that she had psychoses. She wailed like her heart was broken that she would have willingly sacrificed an arm or leg to not have to endure the neuropsychological and social consequences of schizophrenia or any other life-long, life-changing mental illness. Alice lost the precious gift of mental health. It was not her fault; it was not her choice. She was the innocent victim of a brain with abnormalities in structure, circuitry, and chemicals. Alice was the casualty of a war she fought against herself. She suffered from collateral damage caused by an unknown assailant.

My mind went blank for what seemed like an eternity. Then it began to race with a speed that blurred any thought – positive or negative. I needed to answer Alice's challenging questions, or at least validate her feelings and reaction to the fact that someone would make the incomprehensible decision to purposely alter their own mind to mirror that of a psychotic, paranoid schizophrenic. I wanted her to know that I believed her insight regarding the similarities between the psychedelic experience of a hallucinogen and psychosis was profound. I wanted her to stay engaged with me, but I saw she was starting to withdraw. I was concerned she was over-stimulated by the information she read, and her inability to sort through the details and not become stuck on a word or phrase that might trigger a chain reaction of destructive free association. My concern was better than an educated guess. It was her *modus operandi*.

I finally found some words, and attempted to answer Alice; at the same time I assessed her escalating anxiety and agitated state. I was not going to redirect the question back to her as I learned in Therapy 101, because that would have had devastating consequences. In her fragile state, she could have easily felt I was being condescending or dismissive of her feelings. She was hanging on to the ledge with one finger, and redirecting the question back to her would have plucked the last bit of hold she had on her quasi-stability. So I gave the same old answer that has been around since the 1960s: that certain people find the effects of psychedelic drugs to be mind-expanding, not dangerous, and without negative consequences. I shared that I agreed with her feelings, and that I also did not understand experimenting with or using the drug recreationally.

Then I added, "Alice, your connection, and the similarities regarding the symptoms of psychosis and a person's experience under the influence of a hallucinogen, is remarkably insightful. And the people who take such self-destructive risks, and ingest substances that can affect the brain chemistry in a negative or deadly way, are not only ignorant, they are stupid. I know this is difficult, and almost impossible to understand such incomprehensible behavior, or the thought process of the hallucinogen drug abuser – or any drug abuser, for that matter – but thank you for bringing this topic to my attention. I wish I had a better explanation for you, but I don't. We are like-minded on this issue. I, too, do not understand the attraction. But your discernment has peaked my curiosity, and I would like to know more about this growing trend and the fascination with psychedelics in today's society."

I'm not sure whether it was too late for explanations, or too long for Alice to stay on topic. But my optimism that I was experiencing a phenomenon that was the result of 18 months of working on creating a bond, developing an intersubjective dyad utilizing an empathic, humanistic approach, was reduced to 30 minutes of watching Alice's agony at believing she had failed. This sense of failure escalated her anxiety. In an eerie, calm voice that was filled with sadness, she stated, "I have missed the obvious again, Jean. I am incapable of following the simplest formulas of how and why people live and enjoy life. I do not comprehend because I have no ability to understand the desire and fascination of those who ingest hallucinogens for entertainment purposes."

Alice began to yell, "I am the one who is stupid! I am the one who is the half-wit because that son of Satan psychiatrist removed the parietal lobe part of my brain – where comprehension is located! I am to blame for not understanding *why!*"

Alice showed signs of emotional and mental exhaustion. She began to exhibit echopraxia – involuntary eye rolling and exaggerated grimacing (she clenched her teeth together so hard I was concerned she would break them). It was only under extreme emotional stress that I had ever witnessed this symptom in Alice. The last time had been more than one year ago, when her cat was hit by a car and died. Alice felt responsible because she had avoided the cat for some time because she believed her pet was reading her mind.

She moved toward the office door, her teeth now unclenched. Alice clutched her purse to her chest, and crossed her arms around it as if it was a shield of armor. As she walked down the hall to the exit door, she quoted Ephesians 6:11, "Put on the full armor of God so that you can take your stand against the devil's schemes." I was concerned Alice had regressed to a state of religious delusion. I asked if she would like to wait in my office a while before she called a cab to take her home. But with a dismissive wave of her hand, she said, "No."

As Alice began to leave, mumbling about how the chairs in the waiting room were erratically arranged, she stopped to confirm that we were scheduled to meet the following Tuesday at 10. I responded, "Yes." Alice looked directly into my eyes, and, for one brief moment, I felt she was about to say, "Thank you. Thank you for being my therapist and understanding my pain and my need to confront and be validated regarding what I believe to be unjust." She didn't.

I surmised, even hoped, Alice would thank me because we had shared an intense and emotionally intimate session where I was a witness not only to her pain and frustration, but to her strength, determination, insight, and, more importantly, her control over her illness. For 30 minutes of the 50-minute session, Alice showed no sign or symptoms of the "destitute of mind and soul disease", schizophrenia. I was certain she felt the intense bond of that moment, and would validate me as I had her. She didn't verbally, but as she reached for the doorknob, I saw the *Hallucinogens* brochure folded carefully in her hand. That was my validation.

### **Conclusion: The Power of Empathy**

Alice never discussed what transpired that day in any future session. When I broached the subject the following week, she avoided the topic, and launched into a 15-minute monologue about the relationship between the Holy Trinity and the cliché “three’s a crowd.” We continued to meet weekly for about six more months, until Alice and her family moved to Florida. She never missed an appointment, and stayed for the entire 50-minute session from that day forward.

Alice made progress while in therapy. She remained out of the hospital during our work together, and took her medication as prescribed, most of the time. She made a few jewelry pieces and headbands, and sold them to a local gift store. She attended four out of 10 art classes at a studio in a neighboring town. I believe these results were directly correlated to the intense bond created by the empathetic and validating approach I took with Alice.

Alice no longer sat across from the table that displayed the assorted brochures from which she picked the game changer – the one that triggered the breakthrough from psychosis to painful reality, and the spark that ignited the phenomenological experience that validated that we brought our worlds together, resulting in insight and change.

I believe the brochure was a painful reminder to Alice that some people willingly chose to hallucinate, while hallucinations grossly limited and horribly affected her life. I also saw her seat change as a sign of progress that she was able to break free from her compulsive and rigid behavior.

That session was the only time in the two years we worked together that Alice demonstrated a stunningly unique appearance of cognitive clarity. She brought a conscience and inquisitively balanced perspective to her history and current life struggles. For me, it signified a breakthrough, a confirmation that I made more than just a connection with my client, I helped her. Hollan writes,

People who have felt repeatedly violated, intruded on, deceived, or manipulated often find it very difficult to imagine being understood and recognized by others, no matter what the circumstances. Somewhere between these two extremes is where much of the intersubjective work of empathy unfolds, in the transitional space between those who seek to understand and those who can still imagine being understood. (2008, p. 484)

Alice’s fight to stay focused and engaged with me during that session was validation to me that our laborious and painstaking work together was extremely beneficial. Over the time we worked together, we developed a mutual respect for each other’s differences. Even if I did not understand her concerns or delusions at times, she eventually trusted I was there for her.

I was never so aware of my thought process, my compassion, and the caring feelings I had for Alice in her daily fight to understand a society that over-stimulated her that she was afraid of, and that caused her so much pain. I wanted Alice to win, not just her battle with psychosis, but also the overall war of mental illness. Her need for me to be validating, bearing witness to her struggle to stay connected to a life she felt abandoned her, supportive, reassuring, present, empathetic, and in agreement with her perception was never before—in all the months we met—so clear to me as on that day.

For change to occur, insight to be gained, or progress to be made—no matter how slowly or short-lived it may be—cultivating a relationship, and development of the intersubjective dyad, will allow for the power of empathy to heal.

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### Endnotes

<sup>1</sup> According to Matthew Tull, PhD, in his article *The Relationship Between PTSD and Psychotic Symptoms* (2009), psychotic symptoms are divided into two groups: positive and negative. Positive symptoms are characterized by the presence of unusual feelings, thoughts or behaviors; i.e., hallucinations or delusions. Negative symptoms are characterized by the absence of experience; i.e., no emotional expression, no talking, unable to do simple tasks such as getting dressed or bathing.

<sup>2</sup> Information regarding psychosocial and family history was accumulated from several sources such as hospital records, client's self report, family's perspective, previous therapist, and my intake and assessment, which were not specifically identified in this paper.

<sup>3</sup> The reference to despair and the 1800s novelist and poet Mary Anne Evans, who wrote under the pseudonym George Eliot, was regarding a quote from her book, *Adam Bebe*, first published in 1858: "There is no despair so absolute as that which comes from the first moments of our great sorrow when we have not yet known what it is to have suffered and healed, to have despaired and

recovered hope." Evans also lived, unmarried, with writer George Henry Lewes for 20 years.

<sup>4</sup> "A deep place where the sun is silent" is a line translated from *The Divine Comedy, Dante's Inferno*. It is the place in the woods where Dante began his journey with fellow poet Virgil into the depths of hell. It is a metaphor for how Dante was lost and mentally, emotionally, and spiritually empty.

<sup>5</sup> The prodromal phase of schizophrenia refers to the first phase of the illness where symptoms and signs of the disorder have begun to appear, but do not meet the full criteria of the disorder. The active phase of schizophrenia indicates full development of the disorder, when psychotic symptoms such as hallucinations, delusions and grossly disorganized behavior are present.

<sup>6</sup> Alice's comment about the cataracts was significant; I later researched, because many of Monet's works were painted while he suffered from cataracts.

<sup>7</sup> According to Karon and VandenBos, "Many schizophrenic patients, however, to whom the therapist need only say, 'All I have to offer you is understanding, but that's really a great deal,' and they react to it as if he had offered them the Holy Grail. They are impressed when, indeed, he does understand something of their life. The patient has that same kind of 'aha' reaction when the therapist understands something about him, which is basically human. All patients, but particularly schizophrenic patients, do not think of themselves as basically human. They think they are something different from all other people, and that other people could never comprehend their defects, difficulties, and anxieties." (2004, p. 167)

<sup>8</sup> The original brochure could not be located. The information quoted was from *Psychedelic drug*, Wikipedia.

<sup>9</sup> Alice's request to explain why people voluntarily ingest hallucinogen drugs for pleasure has prompted me to explore this phenomenon further, and to research illicit drug-induced psychosis, its permanent effects, and its implications in mental health care.