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# Results of a Transpersonal, Narrative, and Phenomenological Psychotherapy for Psychosis

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In our academically based, psychiatric outpatient practice, we have encountered those who wish to avoid medications for treatment for psychosis. This study is a qualitative/quantitative study in progress of a patient population diagnosed with psychosis and managed primarily without medication. We reflect upon the transpersonal foundations of an approach in which voices and visions are accepted as real, given full ontological status, and addressed within a dialogical framework. We present interim data on a series of 51 patients over 20 years old who presented with psychosis and who remained with us for at least six months in their effort to reduce or eliminate medication. (An additional 201 patients presented themselves for treatment but did not continue for six months.) The practitioners use questionnaires to quantify symptom level, including the Brief Psychiatric Rating Scale, Positive and Negative Syndrome Scale, two depression rating scales, the Clinical Global Inventory, and the Revised Behavior and Symptom Identification Scale. In addition, narrative interviews are utilized in a review of symptoms. Of these 51 individuals, 38 managed psychosis without the use of medication (or with very occasional medication as sleeping assist). Another nine managed well on low dose medications. Three individuals required higher levels of medication and one became progressively worse despite all efforts and was eventually involuntarily placed in the State Hospital. The overall cost-benefit is favorable in creating fewer hospitalization, crises, and diminished suicidality. The results do not hint at one algorithmic solution, but suggest the need for individualized approaches that are client-centered and build upon the previous successes of the person, enroll family and friends in a community effort, and collaborate with those communities to apply those approaches desired by the people themselves. We are optimistic that this dialogical approach to psychosis in which lived experience is granted full ontological reality can facilitate recovery of function in the ordinary, consensual world. Each person's narrative is unique and not necessarily transferable to any other person. How people arrive at successful solutions is varied and makes sense only within their local context and knowledge communities.

**Keywords:** *Psychosis, voice hearers, narrative, transpersonal, phenomenological*

Until recently, psychiatric practice has tended to label the lived experiences of people diagnosed with psychosis as meaningless hallucinations or delusions. Increasingly, however, different perspectives, including that of voice hearers themselves, have prompted clinicians to wonder whether they might be legitimate experiences in consciousness with their own ontological validity. Responsible psychiatric practice means attending to increasing evidence for the limits and dangers of psychotropic medications. To use medications

as front line and ongoing treatment means to ignore a host of studies that have pointed out limitations in their effectiveness (e.g. Schooler, Goldberg, Boothe, & Cole, 1967; Leff, 1992; Gur et al., 1998; Harrow, 2007). Good health outcomes have been achieved differently through recent alternatives such as the Maastricht Approach (Corstens et al., 2009), the Finnish psychosis project and the initiative of Working for Recovery, a Scottish recovery house model. More, there has been a recent resurgence of interest in Loren Mosher's Soteria houses, a re-

examination of the Joseph Burke/RD Laing experimental milieu, as well as a greater investment in the possibilities of narrative approaches, which has meant an increase in hope for a fledgling *recovery* model of well being for those who experience psychosis. With the understanding that 1% of the world's population hears voices, and that the management of these voices is possible and has been achieved by a growing number of people, symptoms and their management can be regarded in a different way, leading to more encouraging goals.

In addition, the first author of this study, Lewis Mehl-Madrona, worked with John Weir Perry in San Francisco and met him as a supervisor during his psychiatric residency. Perry encouraged psychotherapy with psychosis and had a prescient understanding of the discouraging effects of medicating too soon (J. W. Perry, personal communication, 1982).

We present another approach to managing symptoms and sustaining quality of life with the kinds of symptoms that conventionally receive a diagnosis of schizophrenia. In our case, we have undertaken an inquiry into a transpersonal approach, which recalls Stan Grof's spiritual emergency model, but which owes its roots more philosophically and practically to a construct of mind and consciousness found in indigenous thinking.

We introduce a transpersonal model that rests upon a belief that the contents of consciousness have value, whether or not one can understand them, and that extraordinary experiences point toward extraordinary realities that are worthy of serious consideration and further exploration. Our dialogic, transpersonal approach positions these experiences as valid and potentially informative about possible worlds beyond ordinary reality. The treatment narrative we use parallels the story we tell about consciousness and reported transcendental realms—what are they and what can they tell us? The belief in the validity of the contents of consciousness takes one from a materialistic perspective on mind and mental health toward the realm of the psychosocial and the existential where what a person says and experiences makes sense in the world in which they are embedded. In this paper we present one way of many in which a psychotherapy for psychosis is developing from this perspective, from mutual engrossment by practitioner and voice hearer in the phenomenology of the experience, understood dialogically through a continual conversation of clarification and liberation,

which becomes, finally, a coherent understanding of the experience, and allows for transcendence to the shared healing of peers who have been equally wounded. We share some of the outcomes of this work.

### Theories of Consciousness.

Hameroff and Penrose (2013) distinguished three broad categories of theories about consciousness and its contents. In the science/materialist view, they say, consciousness has no distinctive role: "Consciousness is not an independent quality but arose, in terms of conventional physical processes, as a natural evolutionary consequence of the biological adaptation of brains and nervous systems" (Hameroff & Penrose, 2014, p. 95). Chalmers (2012) opined that consciousness is epiphenomenal, lacking independent influence on matter with its holder having the illusory belief that it matters. In this view, consciousness is not an intrinsic feature of the universe. This would be the stance of much of contemporary psychiatry, and would allow one to ignore the visions and voices of psychosis as so much ranting and raving of a disturbed brain, entirely lacking in meaning and content.

The second broad category suggested by Hameroff and Penrose (2014) is embodied in the views of Descartes in which "consciousness is a separate quality, distinct from physical actions and not controlled by physical laws, that has always been in the universe" (p. 95). This follows from Kant's (1781/1998) suggestion that consciousness can causally influence physical matter and human behavior, but has no basis or description in science. In this position, consciousness lies outside of science. Some transpersonal theories fall into this category, though many would ultimately prefer to see science and spirituality linked.

In the third category, "consciousness results from discrete physical events; such events have always existed in the universe as non-cognitive, proto-conscious events, these acting as part of precise physical laws not yet fully understood. Biology evolved a mechanism to orchestrate such events and to couple them to neuronal activity, resulting in meaningful, cognitive, conscious moments and hence also to causal control of behavior" (Hameroff & Penrose, 2014, p. 96). Hameroff and Penrose proposed that the moments in which this happens are moments in which the quantum wave equation is reduced through self-measurement into a single state. In this theory, the Penrose-Hameroff theory of orchestrated objective reduction, moments

of consciousness occur as terminations of quantum computations in brain microtubules, grounding us as humans into one consensual reality and its experiential qualities. Consciousness is an intrinsic feature of the action of the universe and has a legitimate scientific basis for being simultaneously non-physical and grounded in a world of brains.

For those who agree with Penrose and Hameroff, changing the contents of consciousness should change brain structure and function. Schwartz (2003) demonstrated this using functional magnetic resonance imaging (fMRI) for the psychotherapy of obsessive-compulsive disorder. Changes in mind reliably and predictably preceded changes in brain structure and function. We believe that the brains of people with psychosis (and we wonder about dementia) can be mitigated through a psychotherapeutic process that modulates the contents of consciousness and how these are processed and organized. In Penrose and Hameroff's idea of quantum superposition, the quantum wave equation contains all possibilities, but when a measurement is taken or an observation made, it is possible to see only one. They have suggested that one can oscillate among a variety of actual states, but some have more energy and are more entangled with other aspects of the environment and are more probable to be realized and experienced than others.

For a variety of reasons (trauma, drugs, spiritual journeying without a map), people with psychosis may alter those energies and probabilities and find themselves experiencing other actualizations and possible worlds than what are considered consensual by the rest of society. In this way, these individuals may be seen more as adventurers in quantum reality than as patients with diseased brains. Problems arise, however, when awareness becomes "stuck" in these other realities, or when these persons find themselves perceiving other realities while existing in this one. In such situations they become unable to reality test in conventionally expected ways.

From this point of view, the contents and descriptions given by people with psychosis become fascinating accounts of journeys through time and space that many are too grounded in the mundane world to experience. As indigenous elders have put it, those with psychosis go journeying for the rest of us to worlds that we may not want to visit, and they bring back important messages, which they themselves cannot necessarily decipher. That decoding is left to others to realize.

## **Results of a Psychotherapy for Psychosis**

We have found that it is possible to accept the validity of the realities experienced by people with psychosis, and to explore ways to integrate those experiences and dimensions that allow for management of the quotidian tasks of life. This approach celebrates the uniqueness and value of their visions, but also calls their attention to the importance of being able to manage instrumental activities such as shopping, cooking, cleaning, and so forth.

Despite being actively practiced by a growing range of practitioners (Fenton, 2000; see the listserve and website of the International Society for the Psychotherapy of Schizophrenia [ISPS]), psychotherapy for schizophrenia is not commonly mentioned in the psychiatric literature except as a loosely defined, supportive case management task (e.g., Wolff et al., 1997), or as a control condition in studies of other interventions (e.g., Hogarty et al., 1997). Many people who have been diagnosed with schizophrenia do report that psychotherapy was helpful (Coursey, Keller, & Farrell, 1995; Hatfield, Gearson, & Coursey, 1996). Case studies (Lysaker & France, 1999; Lysaker & Lysaker, in press) and some quantitative research (Glass et al., 1989; Gunderson et al., 1984) also show benefits from psychotherapy. Schooler, Keith, Severe, & Matthews (1995) concluded that family treatment provided benefits beyond other psychosocial interventions or usual care, but that there was no evidence for differences in efficacy among family treatments.

### **Limits of the**

#### **Materialist Approach to Psychosis**

Reliance on a materialist model may explain the lack of emphasis on non-pharmacological approaches. If consciousness is epiphenomenal, then changes to consciousness would not change brain structure and function. Despite Schwartz and a developing literature on neuroplasticity (Doidge, 2012), adventures into the implications of new understandings happen slowly.

The pharmaceutical approach has been much critiqued in recent years, and became a highly public conversation with the advent of a comprehensive review of clinical work undertaken by Robert Whitaker (2002, 2004, 2005, 2007, 2011). In 2002, Whitaker published *Mad in America*, a thoroughly researched account of treatment for mental illness in the United States. In it, he drew attention to controversy around the reporting of studies using neuroleptics, and the continued pressure to employ pharmaceutical interventions. In his

“Timeline for neuroleptics” (2004, pp. 11-12), and in the Whitaker Affidavit (2007), prepared for the Law Project for Psychiatric Rights to assist in human rights cases launched by self-named psychiatric survivors, Whitaker outlined the case against neuroleptics. Whitaker began with the common understanding that the modern drug-centered era began in the 1950s with the introduction of chlorpromazine. By 1954 chlorpromazine was found to induce symptoms of Parkinson’s disease. In 1962, the California Mental Hygiene Department determined that chlorpromazine and other neuroleptics prolonged hospitalization instead of reducing it, but in 1963, a six-week National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group (NIMH; 1964) collaborative study concluded that chlorpromazine was a safe and effective anti-schizophrenic drug. Efficacy in the short run meant it was potent and effective in removing positive symptoms so that clients became more manageable. A contemporaneous NIMH efficacy study indicated at the end of six weeks, 75% of patients treated with neuroleptics were “much improved” or “very much improved” as compared to 23% of the placebo patients (Cole, Klerman, & Goldberg, 1964).

Just one year later, these same drugs were found to impair learning in humans and animals, potentially making it more difficult for socially ostracized people to learn how to build healthy relationships (Deniker, 1990). A one-year NIMH collaborative study found that drug-treated patients were more likely than placebo-treated patients to be re-hospitalized (Schooler et al., 1967). In a 1968 withdrawal study (Prién), researchers at the NIMH found that higher dosages received before drug cessation were associated with higher relapse rates. Additionally, a 1992 review by the World Health Organization (Leff, 1992) found that those with first break psychosis who live in countries where they were not able to go to a hospital and receive neuroleptics were more likely to recover and less likely to require further hospitalization.

From early on such results raised concerns that neuroleptics might have the potential to make individuals more biologically vulnerable to psychosis over the long run (Schooler et al., 1967). This finding and possibility has been supported by further NIMH studies and implied in World Health Organization studies (Jablensky et al., 1992). It appears an alteration in the dopamine system may leave patients with psychosis super-sensitized to dopamine, the neurotransmitter believed to mediate the

brain circuitry involved in psychotic events (Chouinard & Jones, 1980; Chouinard, Jones, & Annale, 1978).

While criticism of these treatments has continued to the present (e.g., Whitaker, 2004; Thomas et al., 2014), there nevertheless remains a strong tendency to medicate the first break with neuroleptics to curb acute psychotic symptoms. The individual experiencing the psychotic break becomes more manageable with decreased positive symptoms. Yet in addition to the concern that neuroleptics may sensitize individuals with psychosis to have further breaks in the future, there are also numerous other side effects associated with these drugs such as weight gain, constipation, blurred vision, confusion, and poor memory. By 1992, a neuroleptic-induced deficit syndrome was recognized. In addition to parkinsonism, akathisia, blunted emotions, and tardive dyskinesia, patients treated with neuroleptics suffered from increased incidence of blindness, fatal emboli, arrhythmia, heat stroke, gynecomastia, galactorrhea, obesity, sexual dysfunction, blood dyscrasias, skin disorders, seizures, and early death.

In an often-cited 1994 Harvard study, investigators found that schizophrenia outcomes in the United States were no better than in the first decades of the 20th century and had become worse during the twenty years preceding the study (Hegarty, Baldessarini, Tohen, Waternaux & Oepen, 1994). In 1995, reported relapse rates for schizophrenia patients treated with neuroleptics, outside of study conditions, were found to be above 80% in the two years following hospital discharge, much higher than pre-neuroleptic relapse rates (Whitaker, 2004). In 1998, Gur et al. conducted MRI studies and discovered neuroleptic-induced hypertrophy of the caudate nucleus, the putamen, and the thalamus, and atrophy of the frontal and temporal lobe, associated with greater severity of both negative and positive symptoms. In 1998, Harvard scientists concluded that oxidative stress could be the process through which neuroleptics cause neuronal damage in the brain (Tsai, 1998). In that same year, treatment with two or more neuroleptics was found to increase risk of early death (Joukamaa, 2006; Morgan, 2003).

Another concern raised discussed the limits of testing antipsychotics. Most clinical trials are brief and are aimed for obtaining approval for marketing from the Food and Drug Administration (FDA) and these brief trials may not reflect long-term results (Rosenheck, Swartz, & Lieberman, 2006). In recognition of this, NIMH



initiated practical clinical trials (PCTs), characterized by large diverse and representative samples, prolonged treatment, and practical treatment options. Several of these PCTs (especially the Clinical Antipsychotic Trials in the Intervention Effectiveness or CATIE) focused on schizophrenia and evaluated treatment with first- and second-generation antipsychotics (McEvoy et al., 2006; Stroup et al., 2006). These longitudinal studies found that the effectiveness and acceptability of antipsychotic drugs varied considerably across the various presentations of chronic schizophrenia. A separate study, in rural China, revealed that low doses of medication were as effective as high doses with significantly fewer side effects (Cun, Shinfuku, Bertolote, Bailly-Salin, & Gittelman, 2006). Older medications, largely discarded in wealthier countries, were as effective as newer, expensive antipsychotic drugs.

Medications proved to be far from the hoped-for chemical solution, and instead were associated with many side-effects, undesirable outcomes, and a growing concern from practitioners and consumers that they might be doing as much or more harm than good.

#### **Psychosocial Approaches to Psychosis**

Our practice is one in a long tradition of psychosocial approaches to psychosis that have continued quietly alongside the strictly pharmaceutical practice. Others have provided a comprehensive review of models of psychosocial intervention, especially Mosher (1999). We will therefore aim rather to show the path through which our approach evolved. We trace the origins of our thinking about psychosis to Laing, Perry, Mosher, Lehninen and the Finnish Psychosis Project, and to indigenous elders.

We are aware of Stanislav Grof's work on spiritual emergencies, and feel his approach is useful and consistent with our understanding that people who have experienced some form of sudden connection to a spiritual world may find it unnerving. We certainly feel that venturing into that dimension of consciousness unguided can be overwhelming and create a crisis. We are not sure, however, that he would explain the realms he understands in the way we would, nor that he would grant full ontological status to beings encountered in another realm. For that awareness, we are more influenced by indigenous culture and practice. We are aware of Julian Silverman's (1967) writings on shamanism and psychosis. Many indigenous people in North America have objected to his description of North American

cultures as primitive, reflecting an anthropological perspective that they consider prejudicial and out of date. He described the shaman's experience as abnormal, though concluded that the shaman's reconstitution of self after this abnormal experience was a tribute to the power of surrounding community with the experience of the schizophrenic reflecting the negative view of society toward the experience. He said, "Implicit in this formulation is the following basic assumption: the often noted overt similarities between the psychotic-like behaviors of marginally adjusted shamans and of acute schizophrenics reflect even more basic identities in the cognitive processes that generate these behaviors" (Silverman, 1967, p. 21). However, contemporary research points toward the healer in such communities as being the most stable, instead of marginally adjusted. To cultivate an experience of other worlds and to have it thrust upon one are quite different experiences. Implicit in everything we do is an acceptance of the realm of the transpersonal and its contents, and our framework for understanding the phenomenology of the psychotic experience is grounded in this understanding.

With sensitivity to the felt sense of psychosis, Laing (1967) and his colleagues at Kingsley Hall in London generated ideas about how "a community-based, supportive, protective, normalizing environment might facilitate reintegration without hospitalization" (Mosher, 1999, pp. 143-144). Mosher (1999) brought this to the United States in order to create a place that challenged the assumptions, and as he put it, the "degradation, the induction and perpetuation of powerlessness, unnecessary dependency" (p. 144) that he saw in a medical model belief system. Central to these efforts was the acceptance and validation of the lived experiences of the clients.

Mosher (1999) reflected that he was drawn to the "phenomenologic/existential thinkers" (e.g., Allers, Boss, Hegel, Husserl, Sartre, and Tillich) to create a more open-minded, non-categorizing, no-preconceptions approach to disturbed and disturbing persons. He was also sensitive to the art of the "total institution" (Goffman, 1961); he cited "the authoritarianism, the degradation ceremonies, the induction and perpetuation of powerlessness, unnecessary dependency, labeling, and the primacy of institutional needs over those of the people ostensibly served—the patients" (Mosher, 1999, p. 8). Power and its politics were always a part of Mosher's perspective, inspiring us to aspire for non-hierarchical services. Mosher (1999) wrote:

Despite being trained by psychopharmacologic icons (e.g., Dr. Gerald Klerman), I somehow never found a Lazarus among those I treated with the major tranquilizers. Again, my experience led me to question the emerging psychopharmacologic domination of the treatment of very disturbed and disturbing persons. Actually those persons seemed to appreciate my sometimes, clumsy attempts to understand them and their lives. Because I hadn't found a large role for drugs in the helping process, I was led to believe more in interpersonal than neuroleptic "cures." (p. 3)

Mosher refined Laing's ideas to create the Soteria Project, an alternative to hospitalization. This project's design was a random assignment, two-year follow-up study comparing the Soteria method of treatment with "usual" general hospital psychiatric ward interventions for persons newly diagnosed as having schizophrenia and deemed in need of hospitalization. It has been extensively reported (see especially Mosher & Menn, 1978; Mosher, Vallone, & Menn, 1995). In addition to less than 30 days previous hospitalization (i.e., "newly diagnosed"), the Soteria study selected 18- to 30-year-old unmarried subjects about whom three independent raters could agree met DSM-2 criteria for schizophrenia and who were experiencing at least four of seven Bleulerian symptoms of the disorder. The early onset (18 to 30 years) and marital status criteria were designed to identify a subgroup of persons diagnosed with schizophrenia who were at statistically high risk for long-term disability.

Mosher described the Soteria method as the 24 hour a day application of interpersonal, phenomenological interventions by a nonprofessional staff, usually without drug treatment, in the context of a small, homelike, quiet, supportive, protective, and tolerant social environment. The core practice of interpersonal phenomenology focused on the development of a nonintrusive, non-controlling but actively empathetic relationship with the psychotic person without having to do anything explicitly therapeutic or controlling. He characterized it as "being with," "standing by attentively," "trying to put your feet into the other person's shoes," or "being an LSD trip guide." He aimed to develop, over time, a shared experience of the meaningfulness of the client's individual social context—current and historical. No formal therapeutic "sessions" occurred at Soteria. Therapy took place there as staff built bridges, over

time, between individuals' emotionally disorganized states to the life events that seemed to have precipitated their psychological disintegration. The context within the house was one of positive expectations that reorganization and reintegration would occur as a result of these seemingly minimalist interventions. This context of expecting recovery proves powerful as we are noticing in our current pain research (Mainguy & Mehl-Madrona, 2013).

The original Soteria House opened in 1971. A replication facility ("Emanon") opened in 1974 in another suburban San Francisco Bay Area city. The project first published systematic one-year outcome data in 1974 and 1975 (Mosher & Menn, 1974; Mosher, Menn, & Matthews, 1975). Despite the publication of consistently positive results (Mosher & Menn, 1978; Matthews, Roper, Mosher, & Menn, 1979) for this subgroup of newly diagnosed psychotic persons from the first cohort of subjects (1971-1976), the Soteria Project ended in 1983. Due to lack of funding, data from the 1976-1983 cohort were not analyzed until 1992.

Results were clear that alternatives to acute psychiatric hospitalization are as, or more, effective than traditional hospital care in short-term reduction of psychopathology and longer social adjustment, especially if the patient was without extensive hospitalization. Patients with less than 30 days of hospitalization were especially responsive to the positive therapeutic effects of the well-defined, Soteria-type special social environment.

A number of approaches to treat psychosis while minimizing medication have arisen in recent years. The Finnish Psychosis Project emerged from the work of Yrii Alanen and colleagues (Alanen, Lehtinen, Lehtinen, Aaltonen, & Rökköläinen, 1999), which minimizes medication and emphasizes teamwork, basic psychotherapeutic attitude, family-centeredness and need-specificity. Holma and Aaltonen (1998) described a narrative understanding of acute psychoses through hermeneutical premises. According to their colleague Giddens (1993), this hermeneutical approach is predicated on four premises:

- 1) An object has to be understood in its own terms, that is, as a subject. The other has the authentic right to take his or her role in a dialogue as a full and equal partner. This is the premise of hermeneutical autonomy and guides our work with voices and the beings behind those voices.

- 2) An object has to be understood in context and it is through this that meaningful coherence is generated. Hence, we strive to understand the context of the being of the voice and the context in which our patient has come to intersect with that being's world.
- 3) Understanding has to conform to the actuality of the experience of the interpreter, so-called pre-understanding. All understanding demands some measure of pre-understanding whereby further understanding becomes possible.
- 4) The interpretation of a human product or action must be adequate in relation to the intentions of its originator. Though we may question the conclusions a person makes about the beings behind his or her voices, we never question the validity of the person's experience.

Holma and Aaltonen (1998) constructed mutual understanding through conversation with the individual with psychosis. It was vital to their success that the patient was brought into a dialogue where the meanings of the events they experienced were socially co-constructed. They asserted that diagnosis in the traditional way seemed less essential in the treatment of psychosis than understanding the individual's situation through the story he or she was telling through action and speech. Consonant with Narrative Cognitive-Behavior Therapy (NCBT), the individual should be taken as a valuable participant in social relationships and not marginalized as psychotic or sick. As Hippocrates said, it is more important to understand the person who has the illness, than to know what sort of illness the person has.

In 1997, Aaltonen and colleagues published results of their approach. (Alanen et al., 1999). The two-year outcome of two groups of consecutive patients (total N = 106) with first-episode functional non-affective psychosis was compared, both treated according to the need-specific Finnish model, which stressed teamwork, patient and family participation, and basic psychotherapeutic attitudes. The two study groups differed in the use of neuroleptics: three of the sites (the experimental group) used a minimal neuroleptic regime whilst the other three (the control group) used neuroleptics according to the usual practice. Total time spent in hospital, occurrence of psychotic symptoms during the last follow-up year, employment, GAS score and the Grip on Life assessment were used as outcome measures. In the experimental group 42.9%

of the patients did not receive neuroleptics at all during the whole two-year period, while the corresponding proportion in the control group was 5.9%. The overall outcome of the whole group was favorable. The outcome of the experimental group was equal or better than that of the control group, after controlling for age, gender, and diagnosis. This indicates that an integrated approach, stressing intensive psychosocial measures, can be recommended in the treatment of acute first-episode psychosis.

### **Psychosis Outcomes in Developing Countries**

The World Health Organization's International Pilot Study on Schizophrenia commenced in 1967 to establish whether or not schizophrenia could be found in all countries and whether it could be reliably diagnosed and treated. The study quickly affirmed that the diagnosis could be made everywhere. Gradually, however, the researchers noticed that patients in poor nations had better outcomes than those in wealthier nations. This led to a second study with more rigorous guidelines that tracked about 3,300 patients with 30-year follow-ups in 12 countries—capitalist and communist, Eastern and Western, Northern and Southern, large and small, rich and poor. Again, patients in poorer countries spent fewer days in hospitals, were more likely to be employed, and were more socially connected (Ganev, Onchev, & Ivanov, 1998). Between half and two-thirds became symptom-free, whereas only about a third of patients from rich countries recovered to the same degree (Sartorius, 1992). Nigerian, Colombian, and Indian patients were less likely to suffer relapses and had longer periods of health in between. Doctors in poorer countries stopped drugs when patients became better, whereas doctors in rich countries often required patients to take medication all their lives. Psychotic disorders have better prognoses in developing countries, with higher remission rates

Vedantam, a journalist, wrote a series of articles for the Washington Post in 2005, showcasing the results of the World Health Organization's schizophrenia study. He shared this story:

Psychiatrist Naren Wig crossed an open sewer, skirted a pond and, in the dusty haze of afternoon, saw something miraculous. Krishna Devi, a woman he had treated years ago for schizophrenia, sat in a courtyard surrounded by religious pictures, exposed brick walls and drying laundry. Devi had stopped



taking medication long ago, but her articulate speech and easy smile were eloquent testimony that she had recovered from the debilitating disease. Few schizophrenia patients in the United States are so lucky, even after years of treatment. But Devi had hidden assets: a doting family and an embracing village that never excluded her from social events, family obligations and work. Devi is a living reminder of a remarkable three-decade-long study by the World Health Organization—one that many Western doctors initially refused to believe: People with schizophrenia, a deadly illness characterized by hallucinations, disorganized thinking and social withdrawal, typically do far better in poorer nations such as India, Nigeria and Colombia than in Denmark, England and the United States. The astounding result calls into question one of the central tenets of modern psychiatry: that a “brain disease” such as schizophrenia is best treated by hospitals, drugs and biomedical interventions. (n.p.)

In 1992, The World Health Organization concluded that living in a developed nation was a “strong predictor” that the patient would never fully recover (Jablensky et al., 1992). The better outcome in poorer countries was explained by stronger family ties, which have a profound impact on recovery, and the lack of neuroleptic medication available in developed nations.

Vedantam (2005) observed that

most people with schizophrenia in India live with their families or in other social networks—in sharp contrast to the United States, where most patients are homeless, in group homes or on their own, in psychiatric facilities or in jail. Many Indian patients are given low-stress jobs by a culture that values social connectedness over productivity; patients in the United States are usually excluded from regular workplaces. Indian families sit in on doctor-patient discussions because families are considered central to the problem and the solution. In America, doctor-patient conversations are confidential—and psychiatrists primarily focus on brain chemistry.... “Social factors play a major and important role in the outcome of disease,” Sartorius, head of the study, said. “Very few solutions are medical in medicine.” ... “Social factors are more important than my drug,” said Jose Bertolote, a WHO psychiatrist.

Indian psychiatrists, unlike their Western counterparts, dispense not only drugs but also spiritual advice, family counseling, and even matchmaking services. In the south Indian city of Chennai, psychiatrist Shantha Kamath writes prescriptions for better family ties: When a father asked for her help in arranging the marriage of his daughter, who had schizophrenia, Kamath’s written instructions told the parents how to interact with their daughter and listed the skills the young woman needed to learn before the doctor would arrange a match. (n.p.)

In country after country, WHO found that strong social and family connections trumped pharmacology (Leff, 1992).

Dr. Narendra Wig’s psychiatric hospital in the northern Indian city of Chandigarh could not afford to pay nurses (Vedantam, 2005). Out of necessity, families stayed with patients 24 hours a day. Relatives became the nurses, which turned out to be more effective than nurses (especially at calming agitated patients) and persists today. In India, odd behavior is no reason to isolate someone. Patients with a schizophrenia diagnosis worked, got married, and had children. Relatives and neighbors helped and people got better. Wig (2004) was described as mostly telling his patients about religious figures who overcame obstacles in a kind of naturalistic narrative therapy. He never described schizophrenia as a chronic, incurable brain disease. He encouraged patients to complement his treatment with faith-healing techniques. Social connectedness for patients is seen as so important that the psychiatrists tell families to secretly give money to employers so that patients can be given fake jobs, work regular hours and have the satisfaction of getting “paid”—practices that would be unethical, even illegal, in the United States.

Since 1970s it has been known that the neuroscience findings in what is called “schizophrenia” are largely overlapping with the neuroscience findings found in states of chronic stress, childhood maltreatment (sexual, physical and emotional abuse or neglect), social isolation, and social defeat. The developmental traumatology research convincingly demonstrates causality beyond correlation of the effects of relational traumas and chronic, profound stress on the nervous system, which is something the proponents of “psychosis” as a neurobiological condition have failed to do.

In support of this position, two NIMH researchers wrote that,

Schizophrenia, of course, is not something someone has; it is a diagnosis someone is given. It is worth considering that the syndrome of schizophrenia is not a disease at all, but a state of brain function based on an altered developmental trajectory from early programming with changing repercussions throughout life...That there appear to be numerous genetic and environmental factors that can contribute in various combinations to this recognizable state of altered brain function further suggests that what we call schizophrenia may represent “not the result of a discrete event or illness process at all, but rather one end of the developmental spectrum that for genetic and other reasons approximately 0.5% of the population will fall into.” (Weinberger & Levitt, 2011, p. 408)

This shift in thinking opens up the possibilities and the necessities for new thinking about psychosis and validates the importance of the investigation of the phenomenology of the experience.

#### **Phenomenology of Psychosis**

We are approaching the conceptualization of psychosis and other unusual states of mind from a phenomenological perspective. Phenomenology attempts to describe and explore the reported experiences of others. What is it like for that person? How is his or her psychosis experienced? We want to understand these experiences in their naturally occurring complexity and wholeness (Rhodes & Jakes, 2009). Two topics within phenomenology are particularly salient. The first is the understanding of the self and sense of agency, and the description of who the agent might be. The second is the experience of the everyday world within the agents' lives. In our work, we are also concerned with the being of the other—of the being behind a voice or the being of a vision and are seeking a description of these beings and the worlds in which they live.

Laing (1960) described the sense of discomfort in the world experienced by those with psychosis and labeled it “ontological insecurity.” He believed that people who experience psychosis never adequately developed a secure sense of self. Perhaps the insecurity relates more to the recognition of the spaces between moments of consciousness and the relative arbitrariness of which world comes into our focus. When one grants full ontological status to the voices inside their head, there is a way in which one can never go back to

being the in-control character. Rather, that which one recognizes as “me,” the being constructed to be one's identity, mediates among the other characters who come to occupy the territory of the mind. For people who have been traumatized, some of these characters can be terrifying, occupying spaces and worlds emphasizing fear and danger. When minds intersect with these spaces, ontological insecurity is inevitable.

Behind the symptoms of psychosis there is a felt sense of change by the individual, an alteration of the experience of self, self with others, and self in the world, which is a persistent and profound concern for the individual (Rhodes & Jakes, 2009). This probing of emic perspective is based on accounts of individuals experiencing psychosis, people who relate their experience of not feeling like themselves anymore. They cannot act or talk to others as they used to. They are not the same person, as if the main character in their lives was usurped of identity in various degrees. They are no longer grounded in the ordinary consensual world in the same way as others, who must work hard through spiritual practices and other means to obtain similar visions that come quickly and easily to those diagnosed with psychosis. On the other hand, this slower approach seems to be associated with more positive experiences that are enhancing to lives in the ordinary world, while people with psychosis who are on the fast track to visions more often appear to have negative experiences.

#### **Psychotherapy of Psychosis**

The psychotherapy of psychosis involves, then, using an equitable dialogical approach to create a healing story in the tradition of White and Epston (1990) in which the terrifying characters and emotions are contained and managed. We aim to help people settle into a lived world in a more syntonic manner. People with psychosis can learn to function better in this ordinary world even as they perceive and interact with extraordinary worlds. In this way, we externalize the problem and revise the person's relationships with the problem. In our work with narrative, which we accept as the framework for meaning-making, we believe we enhance their frontal lobe function, those areas concerned with story, so that people become better able to error detect, do theory of mind (of others), inhibit extraneous responses (orbitofrontal cortex), and predict consequences. Building better stories means building better judgment.

Oft described, though difficult to put into words, are a wide range of alterations in perception of things, time, and space (Rhodes & Jakes, 2009) that come to those with psychosis and may be explainable by Penrose and Hameroff's theories of consciousness. Being in the world seems different to those experiencing psychosis. Rules inherent to those grounded in reality are not so apparent. In our approach, we accept unquestioningly the reality of people's lived experience, even as we focus on how to have extraordinary experiences and still function in the ordinary world. We try to restore the lost or shaken natural attitude, common sense, or what Minkowski (1927) called the "vital contact with reality," so that life can happen more seamlessly (Sass, 2001). Rhodes and Gipps (2008) have described this alteration in perception as a "background" disturbance. Individuals with psychosis experience the surrounding world differently, whether temporary or permanent, specific or global in scope (Rhodes & Jakes, 2009).

This perspective on psychosis is compatible with many indigenous cultures. Health care providers and institutions supporting their work have a predominately etic perspective of psychosis because they are not experiencing it. An emic perspective of psychosis is harder to attain and even more difficult to deliver. One has to be willing to enter into the lived experience of the client and grant it validity. There can often be confusion generated because of differences of experience between those helping and those in need of help.

Outcome research is somewhat limited. Okuzawa et al. (2014) reviewed studies on cognitive-behavior therapy for people at high risk for psychosis and found six qualifying studies with a total of 800 participants. Three trials achieved a significant effect. The two trials that employed cognitive behavior therapy enhanced for the specialized needs of clinical high-risk patients maintained significant effects at post-treatment follow up. They concluded that "evidence from recent trials suggest that cognitive behavior therapy may be beneficial in delaying or preventing onset of psychosis in clinical high-risk individuals.

### **Treatment Philosophy.**

Our philosophy of approach follows that of Rhodes & Jakes (2009) with the following features:

- Focus on solutions, resources, and strengths of the individual
- Prefer solutions generated by clients with respect for

their inherent creativity

- Investigate unique outcomes and exceptions to the client's illness story
- Assume that the individual exists in a network of influences, both historical and contextual
- Use non-technical terms for difficulties
- Emphasize language, metaphor, narration, and discourse
- Be open to theories such as: neurology, phenomenology, developmental theory etc., but also the theories of indigenous people and of the clients themselves.
- Focus on constructing together a healing narrative.
- Make little to no attempt to educate
- Use the imagination to build a full picture of a preferred future
- Combine assessment and intervention into one process
- Maintain a holistic model of causation
- Radical acceptance of the contents of the psychosis experience, such that mitigating ideas are presented in a way consistent with the metaphors being offered.

We applied these narrative practices in a locked inpatient psychiatric facility (Mehl-Madrona, 2005) applying concepts from Vassallo's (1998) case report of a narrative group for seriously mental ill, seeking to challenge "normalizing judgments," defined as practices that evaluate and classify people and relationships according to the truths of a dominant culture. In this case, the dominant culture is the psychiatric establishment and the day-to-day practice of categorizing people, labeling the manner of their defect, and then providing specific biological therapies (medications) in accordance with current pharmacological theories about what would work for this particular defect in biology and genetics.

Working with Anthony's (1993) ideas of recovery, we conducted groups from the perspective that people can improve without professional help and that professionals do not necessarily hold the key to recovery. The individuals do. We believed that a common denominator of recovery is the presence of people who expect recovery with confidence as they bear witness to the suffering of the individual. Community is a more than adequate substitute for the mental health system. In the group we challenged the dominant cultural story of people's brains being defectiveness as the cause of their chronic mental illness. Implementation of our approach

improved outcomes compared to other units in the hospital that continued to function in the conventional manner. We wanted to make some progress in moving from an expert driven model (implicit in everything about how hospitals function) to co-constructed models arising from all concerned with the person who suffers.

What we are doing is making story together, which is how we construct shared meanings. We create and maintain our stories about how things work and what they mean in dialogue with others. Through our relationships and the stories told in those relationships, we also construct and maintain an identity (which is a story about who we are), which has more or less of a sense of personal agency. Shotter (1993) has called this dialogical or conversational social constructionism, which is the idea that we co-create each other through our responsive understanding and the communication of that understanding to each other. Hence, in our work with psychosis, we are trying to create an accepting community of mutual understanding and influencing of each other's stories in which all utterances have validity, regardless of how fantastic (or boring) some may be.

### **Diminishing the Expert and Peer Helping**

We aimed to diminish the role of the professional as expert. Though an event occurs, the meaning attributed to the event is salient, since meaning is constructed by all participants in the event. The expert paradigm can be appropriate to certain degrees and offer benefit. However, the implicit power differential between expert provider and recipient of care in the patient position can leave the patient's perspective marginalized, and can inure the care provider to the importance of the relationship with the patient and to the validity of lived experience. This can seriously impede socialization and recovery for the person diagnosed with psychosis. Additionally, the care provider's constructions of reality are offered more credence, which can be ontologically dangerous.

When the expert model becomes more flexible and allows other stakeholders, primarily the patient, to have a voice, the patient and the healthcare system can benefit. Hermeneutics and dialectics are ways to allow more and varied stakeholders into the system (Heppner, Wampold, & Kivlighan, 2008). Hermeneutics refers to the activity of discovery and interpretation of individual human thought. This method is vital in developing an interpretation of the experience of someone with psychosis, and moves us toward a helping and healing relationship. The interaction between caregiver and

patient can be described as dialectical. Dialectics are expressed and developed through conversation with the patient, and with the sharing of interpretations of the patient's experience once rapport has been established. The power of dialectics emerges as our mutual understanding changes as we share our interpretation of conversations in which all stakeholders participate. In the dialectical relationship, the patient is given credit for being a human with rights of autonomy, active in creating his or her own new experience. This differs from the expert medical model, which can be characterized as a mostly linear flow of information and power, in being a relationship that is recursive and engaging of both parties.

In conventional psychiatry, illness is "discovered" by experts through documentation of a certain number of symptoms that can be theoretically, objectively verified or falsified. These definitions are codified within the DSM (APA, 2000). A radically different approach, which would be non-hierarchical, can be derived from philosophers such as Bakhtin (Clark & Holquist, 1984), Volosinov (Shotter, 2004) and Medvedev (The Bakhtin Center, 2004), all of whom tried to account for human behavior socially: by looking at how individuals relate when communicating. For them, dialogue is the medium whereby people create and sustain their ways of living together—the glue for co-existing. For them, psychosis would arise through sustained patterns of communication. In our view, voices encountered are also part of that dialogue and should participate in the meaning-making about themselves.

The terminology of conventional psychiatry (including the wording of the diagnostic criteria for psychosis), and the operations defined as treatment, gives the clinician privilege and authority in making decisions about the patient. It is up to the clinician to determine what is clinically significant, what questions to ask, what stressors to consider, and what areas to explore, leaving the patient with a prescription for medication and behavior, and rarely engaging him or her in a problem-solving dialogue. Foucault (1969) wrote about the means by which languages of knowledge legitimize the consolidation of power in one group (psychiatrists) over another group (patients), with the smaller group explaining and defining the larger group's reality.

Richard Bernstein (1985) wrote, "It is our cultural understanding of science, especially the physical sciences, and the remarkable 'success' of the scientific enterprise since its modern origins that has set the context



for the intellectual and cultural problems in the modern world...there are deep cultural reasons and causes—as Gadamer, Arendt, and Habermas have argued—why in the modern world the only concept of reason that seems to make sense is one in which we think of reason as an instrument for determining the most efficient or effective means to a determinate end, and why the only concept of activity that seems viable is one of technical application, manipulation, and control” (p. 46). This appears to explain the motivation driving contemporary psychiatry. However, as Whitaker (2011) pointed out, that approach is not actually working very well.

### **Carving out the Continual Conversation**

In Bakhtin’s perspective, humans live in continual conversation (including internal conversations) with actual or anticipated others. In our conversations we are continually negotiating what we mean. The signs and symptoms labeled psychosis result from these conversations, perhaps even as misunderstandings. Mikhail Bakhtin’s philosophical orientation concerning dialogue and difference is captured in a methodological application called “dialogism,” which offers a significant challenge to contemporary medical practice and its location within authoritative discourse (White, 2014). According to Bakhtin, dialogue, as an antidote to monologism generates difference and, as a consequence, has the potential to expand the capacity to cross cultural and individual borders in a process called transgression (Holquist, 2009)

Bakhtin’s optimistic view (White, 2014) rendered each human being into an author who works hard all the time at co-authoring with others to have good relationships. Psychosis in its most symptomatic form could be seen as a breakdown in co-authorship. The person in a psychotic state loses the ability to draw on words and ways of speaking (discourses) to make sense to others, to make requests of others, to repair disrupted conversations, and so on. But, thinkers like Bakhtin would see the psychotic conversation, even as monologue, as valid and important. This makes conversation an infinite challenge. A conversational view of psychosis would argue that pharmacotherapy is one type of conversation, but there are others. The question of which conversation to hear would move toward issues of practicality and preference.

The project of modern medicine is to have complete, correct knowledge of disease (defined as physiological and within individual biological entities), to

have evidence-based best treatment recommendations, and, in essence, to tell people what to do to get healthy and stay healthy. This is also the goal of most of alternative medicine, though the methods differ. The larger question which some would like to consider, is the question of whether or not this is possible. Within what is coming to be called narrative medicine, it is possible to inquire about the long-term socio-cultural and biological effects of applying the biomedical expert model, and about whether or not biology exists independent of culture. Within the conventional psychiatric model, culture is an add-on, an after-thought, something to be addressed once the biological factors have been considered and addressed. It may also be that culture drives biology and biology shapes culture so much that the two are inseparable.

Does the American Psychiatric Association’s *Diagnostic and Statistical Manual* add anything to contemporary mental health treatment? Recently Thomas Insel (2013), Director of the National Institute of Mental Health, rejected the DSM as a stand-alone valid classification tool, since it has no grounding in biology. However, it is culturally created and creative of culture. With its continual “further specification” and “fine-tuning” of diagnostic criteria, it aims to classify people into finer and finer distinctions. Many agree that it justifies and perpetuates a massive and powerful industry, which perpetually revises itself. Someone from another culture or theoretical, diagnostic system might argue that this massive investment in the classification of disorders produces and reifies the problems that it sets out to study. These people might say of DSM what Jung (1939/1966) said of Freud, that Freud (and, arguably, the psychiatric industry)

constantly had the clinical picture of neurosis before the mind’s eye—the very attitude that makes people ill and prevents them from being healthy. Anyone who has this picture before him always sees the flaw in everything, and however much he may struggle against it, he must always point out what these demonically obsessive pictures compel him to see” (p. 45).

Rom Harre (personal communication, June 23, 2004) noted that,

Most of the people who have the gall to declare some practice to be unscientific have a very primitive

idea of what science is. Science is not a series of discourses arranged by deductive logic. It is a cluster of practices at the core of which is classification of phenomena and the making of models.

The positivist idea of “science” may have done harm to psychology, not least because people thought there must be “measurers,” numbers, experiments, variables and so on, and took on statistics as a way of meeting this “obligation.”

Even in the biological sciences, there are many complex phenomena that cannot be reduced or deduced down in artificial experimentation that take out external validity factors, or as you say, there are many uncertainties and complexities of physics.

We are wondering about alternative voices to bring to the table of explaining human behavior. Bakhtin was fond of Dostoevsky’s ways of bringing forth the “voices” of his characters without giving any voice supremacy. Bakhtin defined polyphony as “a plurality of independent and unmerged voices and consciousnesses” leading to multiple—if not infinite—potential meanings depending upon whom is participating in the creation of that meaning. One voice (as truth) is monologue, a stifling of those dialogic potentials.

We would prefer to arrive at something holding the social role of truth through consensus, and propose that the voices stifled by contemporary psychiatry should be included. The more voices, the better, since meaning arises as the product of multiple voices in a continuous dialogue that never arrives at any final conclusion. This is what we are also proposing for the voices that exist within the mind. Meaning is an accomplishment constructed through communication, including the communication with the inner voice. They have something to add to the communication that creates meaning, as do the voices of the community in which the sufferer finds himself or herself. Creative understanding is an unending process whereby dialogue creates that which is shared and different about people. This is why many are uncomfortable with the current biological emphasis in psychiatry—it eliminates large blocks of voices from the dialogue.

Alternative health practitioners, or clinicians and communities whose theories differ from the official version, might miss out. An alternative way of constructing any mental disorder is by listening to so-called patients in

a way that is confident enough to co-create a different story than the official, diagnostic version.

What happens when one operates on this idea that all human experience is valid, including the extraordinary? What happens when each person is approached with respect and curiosity? Regardless of how much difficulty a person has negotiating his or her way through the ordinary world, their non-ordinary experiences can be profound, potentially replete with wisdom and guidance for others, and revealing of other unexamined dimensions of lived experience.

### **Preliminary Report on Outcomes**

Sufficient clinical work has been done to warrant preliminary reporting of clinical outcomes. The report summarizes the work of two of the authors (LMM and BJM) who have interacted over time with 51 consecutive qualifying patients diagnosed (elsewhere) with a psychotic disorder. Patients are only included in this reporting if they had stayed with us for at least six months. (During this same time period, 201 patients came who did not stay for six months of treatment.) Diagnoses included schizophrenia, bipolar disorder with psychotic features, psychosis not otherwise specified, and schizoaffective disorder.

Baseline questionnaires were administered to all participants. These consisted of the Positive and Negative Syndrome Scale (PNSS; Kay, Fiszbein, & Opfer, 1987), the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962), the Hamilton Depression Rating Scale (Ham-D; Williams, 1988), the Montgomery-Åsberg Depression Rating Scale (MADRS; Müller, Himmerich, Kienzle, & Szegedi, 2003), the Clinical Global Inventory (CGI; Guy, 1976), and the BASIS-24 (Eisen, Normand, Belanger, Spiro, & Esch, 2004). These questionnaires were re-administered at quarterly intervals.

Table 1 shows the diagnoses for patients who began doing narrative therapy with the authors along with the average length of follow-up. What is clear is that the narrative psychotherapy of psychosis is a long-term proposition, typically measured in years rather than weeks or months. Yet the failure rate in this sample is low (7.8%), as is the number of patients requiring ongoing medication (9.8%). Over 60% of patients had resolution of symptoms without any medication, and over 20% of patients required only low dose medication.

Table 2 shows changes occurring in some basic outcome measures over the course of treatment. The results clearly show that most people who stick with the

approach (for whatever reason) do largely improve on all baseline measures. However, the caveat is embodied in the question, why do so many people not continue? Potential answers include the reality that psychotherapy is work and much of contemporary culture socializes people to want quick solutions to health issues, often in the form of a pill that does not require effort. It may also be that the more severe cases are not able to build sufficient rapport to persevere for six months in psychotherapy.

### Clinical Cases

Consider as an example a woman whom DSM-IV-TR (APA, 2000) would classify as psychotically

depressed. This woman, however, interpreted her “illness” as a sign from God that she should stop her heavy involvement with her local church, quit employment, retreat, and be ill for a certain period of time. Nearing the end of her time of rest, she felt vindicated, she wanted to talk, and she sought therapeutic help in the form of counseling and group therapy. She did not want to discuss the symptoms in any great detail, and was more interested in finding out how other people experienced her in an interpersonal setting. She felt the need to consult with therapeutic professionals, to talk, and seemed to value this experience. Yet this process did not replace or heal her withdrawal, perhaps because

**Table 1.** Patient diagnoses and follow-up length in narrative therapy.

DSM Diagnosis	Total Patients	Number with resolved psychotic symptoms on no medications	Number resolved with low dose medications	Number requiring ongoing medication	Failures	Average length of follow-up (years)
Schizophrenia	15	7	6	1	1	12.9
Psychosis Not Otherwise Specified	14	11	1	1	1	6.9
Bipolar affective disorder, psychotic	8	5	1	1	1	2.1
Substance Induced Psychotic Disorder	9	4	2	2	1	2.2
Schizoaffective Disorder, currently psychosis	5	4	1	0	0	2.1

**Table 2.** Changes occurring over the course of treatment.

Data Report Format: Pre-score (SD) to Post-score (SD)	Total Patients	Number with resolved psychotic symptoms on no medications	Number resolved with low dose medications	Number requiring ongoing medication	Failures
Totals	51	31	11	5	4
PNSS	51	46.1 (31.2) to 2.6 (1.2)	51.2 (22.4) to 5.1 (3.1)	61.2 (22.4) to 51.4 (11.5)	45.1 (46.1) to 31.2 (51.2)
BPRS	51	104 (13.1) to 22.6 (2.5)	122 (24.5) to 13.1 (11.1)	54.5 (11.1) to 54.5 (11.1)	54.5 (11.1) to 115.1 (11.1)
Ham-D	51	30.1 (7.1) to 0.9 (0.7)	31.1 (24.1) to 3.4 (0.94)	31.2 (26.1) to 10.2 (3.1)	25.1 (22.2) to 22 (2.2)
MADRS	51	26.1 (31.2) to 4.9 (4.4)	26.1 (25.1) to 5.1 (2.2)	25.1 (31.1) to 21.3 (12.2)	31.1 (11.5) to 22.2 (12.5)
CGI change	51	-3.1 (2.2)	-2.2 (1.6)	-1.0 (1.2)	1.0 (1.5)
BASIS-24	51	30.1 (31.2) to 9.4 (9.1)	26.1 (25.1) to 22.2 (13.1)	33.1 (31.2) to 22.6 (12.5)	26.1 (25.1) to 22.5 (13.1)

she did not regard her actions during that period of her life as particularly disordered. Quite the opposite, in retrospect—whatever it was, whatever it did—it appeared to be the right thing. Her story differed from the conventionally accepted story. Improvement came when God was allowed to speak and to declare what her experience had meant and for those bearing witness to her story to accept her interpretation.

Another woman, Betsy, presented with visions of a big buffalo head. She saw two big horns and a huge buffalo robe. She would climb on top of this buffalo, on top of his head, and stand on his hump to see further than she could see on her own. Her little sister periodically appeared. A cousin had abused Betsy sexually when she was ages 4 to 6, and she had come to believe that this defined her. Her abuse stopped with the sudden death of her brother. She felt guilty, for perhaps her brother had died for her. This led to an uncomfortable stillness. She could feel the hands of her brother. They felt “really weird, hard and not cold, not supple, though looking soft.” She knew he wasn’t there, but his hands were. His hands were at room temperature when she had touched him in the casket and this had disturbed her. She was thirteen then. In the year before seeing me, she had experienced a recurrent dream of waking up in shallow water in the early morning with the sun overhead. She often had dreams of breathing underwater. Something grabbed her by the collar and pulled her out of the water, telling her to go. She believed it was a leopard-jaguar combination animal. She remembered going back and forth, in and out of her body. She remembered the incredible stillness of being outside her body. She felt a bubble around her, a bubble of stillness. Then she was one with a large ocean turtle on an expedition into the ocean’s depths to find a sacred pearl. She practiced breathing for this long journey in the dark with only a few glimpses of moonlight.

When we discussed this, Betsy told me she was from a star. She had to twist herself into uncomfortable shapes when she came to earth to relate to people. These shapes were not her. She had to go back to the stars to feel her power. She remembered being at a health club on the ocean in which the warmth of the sun passed through the glass and the seagulls lined up outside. It was early morning and the sun was overhead. She felt someone grabbing her by the collar and pulling her through the window and into the water. She rose up to return to being a star. She felt the power within her.

Results of a Psychotherapy for Psychosis

She talked about her mother dying two years previously. She had never grieved her mother’s passing. There had always been so much fury between them. In her vision she saw a bear in the woods. The bear was related to her but also separate. It was talking about powers she didn’t have yet but could get, evolving energies.

Improvement came when we created a dialogue with all these internal characters from her visions and dreams in which each spoke for itself. We used puppets to represent these characters and placed them around a table. Each was allowed to speak until all came to a negotiated compromise that included the actual physical people who also shared her life.

A third patient believed that he was cancer embodied. His agency at causing death for others made him feel alive. He was a burning funeral pyre, aware that he would die, but going out in a glorious manner. He perceived himself as having been in a great battle and having fought valiantly, but having been mortally wounded. He wore his wound proudly as a burning flame, his badge of courage, his purple heart. We were able to let the cancer speak and to allow him to negotiate with it and with other characters who *didn’t* want him to be cancer embodied to arrive at a more satisfactory stance about his life.

In keeping with good clinical practice, I contacted relatives, friends, former doctors, and obtained collateral stories from these people to provide further depth to their stories.

In these representative three stories, people have broken free from the biological psychiatric narrative. They spend no money on drugs. Their daily “meds” include yoga, meditation, prayer, all embedded within community. They have alternate stories, which would be unnoticed by the dominant paradigm. If noticed these stories would likely be dismissed as “quacky,” so rare that a significant number of people would find them unimportant and/or evidence of misdiagnosis (since bipolar disorder is, by definition, life-long).

### Discussion

Rob Harre (personal communication, June 23, 2004) observed that science has two aims: to find a good way to classify and pick out phenomena of interest, and to find a good way to account for what is going on with those phenomena. It is just a disciplined way of looking at things. We propose a different way to think about extraordinary mental phenomenon.

*International Journal of Transpersonal Studies* 71



When the voices heard by our clients are dismissed as meaningless, the construction of meaning that can be so healing is derailed. Creative understanding is an unending process whereby dialogue creates that which is shared and different about people. This occurs both inside the mind and through meetings with other minds.

These stories represent a repository of transformation, and help for the today's non-responders—an alternative that has other solutions in addition to medication or besides medication, as the case warrants. Each individual has his or her own path to lessen suffering. The solution develops from the affected community and not the professional expert.

Within each of our clients, we saw their impulse to create shared and multiple understandings even when circumstances prohibited that. For these people, their dialogue placed them as authors of their own stories, narrators of their desires, and contributors to their “truth”—while still continuously borrowing from the words and discourses available to them to coexist with their fellow humans. Our clients were aware that their stories lay outside what was considered acceptable in most cases. For them, one size did not fit all.

Bakhtin believed that

within the arena of...every utterance an intense conflict between one's own and another's word is being fought out....This happens both in the external world but also the internal, experiential world of our minds, in which some character inevitable disagrees with whatever comes forth from our lips. The immediate social situation and the broader social milieu, both within our minds as maps of the outer world complete with bleed throughs from other realities and determined by the outer world, wholly determine the structure of an utterance.” (Clark & Holquist, 1984, p. 220)

Bakhtin reflected the state of mind within so many of our clients' minds—a state of war among conflicting and competing voices.

Through dialogue that affirmed the lived experience of people diagnosed as psychotic, people recovered from what was called psychosis. The fact of this recovery pushes us toward a social brain hypothesis, that human relationships remodel and rewire the brain more effectively than pharmacological agents.

## Endnotes

1. These modalities including nutritional strategies, micro-nutrient therapies, homeopathy, craniosacral therapy, reiki, ritual and ceremony, prayer, traditional Chinese medicine with or without acupuncture, hypnosis, visualization, yoga, T'ai chi, exercise, chi gong, and others.

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