# First person accounts of psychotherapy for psychosis

# A hermeneutic investigation

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**Attestation of authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by any other person (except where specifically defined), nor any material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or any other institution of higher learning.

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**Abstract**

There is a growing amount of research focusing on the effectiveness of psychotherapy for psychosis but there is very little written about the experience of psychotherapy from a client's perspective. This is despite researchers acknowledging the benefit of hearing directly from the client. The purpose of this dissertation is to investigate what people who have experienced psychosis have to say about their predominantly psychodynamic psychotherapy encounters. The research criteria focus exclusively on published first person accounts. It is hoped the research will provide a deeper understanding of what people who have experienced psychosis have found both helpful and unhelpful psychotherapeutically to better inform practice in this area.

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## Chapter 1: Introduction

The purpose of this dissertation is to discover what people with lived experience of psychosis have to say about their psychotherapy encounters, with a specific focus on psychodynamic psychotherapy. Drawing upon the selected literature I will examine people's responses to their therapeutic experiences, taking notice of what is believed to have helped and/or hindered the recovery/healing process.

### The inspiration

Almost twenty years ago I was employed by a community mental health organisation to design and deliver vocational programmes for people living in the community who experienced significant mental distress. Many of these people had been in the psychiatric institutions that were closed down in the 1990s, and the new focus was upon 'de-institutionalisation' and 'reintegration into society'. This meant delivering programmes in the community, rather than at a mental health centre. Transportation was a collective affair by bus instead of a minivan from a mental health facility.

One of the programmes I devised was 'art gallery tours' where a group would every week visit an art gallery and have a session afterwards discussing the art and having a coffee at a café. At the time such a publically based concept was uncommon. There was one man in the group who I shall call Rhys, and on the first day of the tour he told me he would drive to the art gallery and meet us there. When I asked him why he didn't want to catch the bus with the rest of us he told me that people always said horrible things about him when he was in public. I asked if he would feel comfortable sitting with me on the bus and letting me know when he heard such things, and he cautiously agreed. We sat on the bus together and there were two women behind us speaking what may have been Mandarin or Cantonese. Rhys whispered to me that he could hear them saying he was a loser with no friends. I told him that I understood it might have sounded like that, but to my knowledge they were speaking a different language. He looked relieved.

When we got off the bus a group of people ahead of us burst out laughing. Rhys stopped still and told me the people were jeering at him. Again, I said I understood the feeling that people might be laughing at him but they weren't looking at us. His body relaxed. The visit continued along this vein, Rhys telling me when he thought he heard people saying negative things about him and me accepting his distress whilst giving him my perspective.

It was on the way home when I experienced a moment that has stayed with me since, and cemented my determination to work with people who are often labelled, misunderstood and treated as 'other'. We had just got off the bus and a group of people walked past. Rhys turned to me with a look of amazement. He told me he had just heard someone say, "There goes Rhys, what a great guy, look at him with all his friends". He said it was the first time people had said nice things about him in public.

This time I didn't share my interpretation of the event. I was marvelling at how something so simple, a group excursion with accepting people, could make such a difference to how someone could perceive himself. As the programme continued over the year I observed Rhys' anxiety transform into confidence and a wry sense of humour.

**Making sense**

In a recent research study, Bjornestad et al (2018) explored what fully recovered service users found to be the working ingredients of psychotherapy in the recovery process after psychosis. They identified five key themes: "(1) Help with the basics, (2) Having a companion when moving through chaotic turf, (3) Creating a common language, (4) Putting psychosis in brackets and cultivate all that is healthy, and (5) Building a bridge from the psychotic state to the outside world" (p.1).

When I reflected on my encounter with Rhys, I realised each step was covered in our weekly interaction. Whilst our interaction did not take place within a typical psychotherapeutic setting, i.e. a one-on-one 50 to 60 minute session in a private space, the components were similar. Encouraging social

interaction was an example of helping with the basics; supporting Rhys with this transition was similar to having a companion when moving through chaotic turf; communicating honestly and openly created a common language; focusing on a creative outlet put psychosis in brackets; and ‘reality testing’, in the sense of sharing my perspective of a situation, was building a bridge from his psychotic state to the outside world.

I think because of the experience with Rhys, I became passionate about the treatment of psychosis, and angered at the stigma that is so prevalent with psychotic or ‘schizophrenic’ disorders. I became involved with the ‘Like Minds Like Mine’ programme and project managed campaigns designed to re-educate people about the diagnosis, and to help people see psychosis as an understandable part of the human condition and that recovery was possible. One project involved interviewing nine people who heard voices to better understand their perspectives of their experiences, in particular, what they believed had hindered and helped their eventual recovery.

**The present**

Now that I am practising as a psychotherapist, and trained according to a psychodynamic model, I am particularly interested to discover what people who have experienced psychosis have to say about their psychodynamic therapy experiences. A psychodynamic model incorporates such principles as paying attention to unconscious processes and defences, understanding how attachment styles and childhood dynamics impact the present, and acknowledging the influence of the therapist/client relationship.

Early on in my initial literature search I was further inspired by an article written by a woman who had experienced psychosis, that discussed some of her psychodynamic therapy experiences -- the positive and the negative. Whilst she appreciated the approach can create a space for people to find meaning in what others often dismiss as “incoherent or ‘mad” thinking (Waddingham, 2016, p.274), she also wondered about an uneven power dynamic, where the therapist applies rigid structures and interpretations to someone’s difficulties from an expert position. I found myself agreeing with

many of her critiques, causing me to wonder: what have other people's experiences been of psychodynamic therapy for psychosis? As I embarked upon my literature review, my next question was: and why is it so difficult to find anything published?

**The gulf**

There is a growing amount of research focusing on the effectiveness of psychotherapy for psychosis that includes a specific focus on psychodynamic psychotherapy (Gottdiener, 2006; Alanen, Gonzalez de Chavez, Silver & Martindale, 2009; Josias, 2009; Rosenbaum et al, 2012; Summers & Rosenbaum, 2013; Harder et al, 2014). However, once I started my search for first person perspectives of psychotherapy for psychosis, I discovered rather than locating a gap in the literature, I had encountered a gulf. This was despite researchers acknowledging the benefit of hearing directly from the client with psychosis. Some examples: Bjornestad et al (2018) states, "Service user perspectives on recovery-facilitating therapeutic interventions are called for. They could help suggest hypotheses about what constitutes the helpful ingredients in therapy" (p.2). Gold (2007) declares, "First-person narratives of life before, during, and after psychosis are compelling and can inform treatment and recovery" (p.1271). Wood (2010) observes, "Service user voices are not prioritised and it is essential their perspectives are integrated meaningfully into a given evidence base" (p.803).

Whilst case studies are often included in research findings, they are generally written in third person, and thus viewed through the lens of the researcher (Gleeson et al., 2008; Fuller, 2013; Lotterman, 2015). The few 'first person' findings (Wood, 2010, Bjornestad et al., 2018) were merely quotes, and again selected by the researcher.

**Wondering why**

This contradiction between an acknowledgment of the benefit of first person accounts and the lack of existing material raises questions of its own. Thornhill, Clare & May (2004) partly attribute the dearth of literature focusing on subjective accounts of psychosis and recovery to the twentieth century's

preference for objective, positivist scientific methods such as statistical analysis of numerical data (p.182). The authors call for research methods that "allow for an understanding of the lived experience of individuals through the study of language and meaning in texts" (p.182).

I also wonder if reluctance from researchers to provide comprehensive first person accounts of psychosis is connected to an unacknowledged counter-transferential response to common psychotic dynamics, such as fragmentation, dissociation, confusion and what Bion (1962) terms "nameless dread" (p.96). With interviewees viewed perhaps as unreliable narrators, researchers may feel the need to contain and constrain such voices, thus the prevalence of short quotes and case studies written from the researcher's perspective. I note, even in the International Society for Psychological and Social Approaches to Psychosis' (ISPS) collection of texts, an organisation committed to de-stigmatising and normalising psychosis, the initial imbalance of clinical and first person accounts. The majority of texts to date do not include first person perspectives of psychosis, and those that do, pair the accounts with clinical interpretations (Garfield & Mackler, 2009; Geekie, 2012; Taylor, Gianfrancesco & Fisher, 2019), undermining the efficacy of the first person account.

**Terminology**

I am mindfully using the term psychosis because research has revealed the diagnosis schizophrenia increases both self and societal stigma, mainly due to its association with a biological/illness framework, and the idea that to be 'schizophrenic' is a fixed state where recovery is not possible (Kennard, 2009, p.96).

However, ideally I would prefer not to use an overall term at all. Read & Cornwall (2019) make the observation that our brains seem to be programmed to require a label or word to describe our experience, particularly if we are observing something distressing or unusual (p.672). They support the argument that swapping one diagnostic word for another does not reduce stigma, and we should instead describe the specific behaviour a person is experiencing, i.e. hearing voices, believing things that others don't, speaking

in a way that others find hard to follow, and experiencing periods of confusion where you appear out of touch with reality (British Psychological Society, 2014, p.10).

In her thesis focusing on the experiences of Māori diagnosed with psychosis, Taitimu (2006) uses the term “extraordinary experiences (EOE)”, reflecting a common view by Māori that their so-called psychotic experiences are in fact an understandable reaction to their environment, whether the origins are spiritual, ancestrally linked or trauma-based.

In terms of this dissertation, what I believe is of primary importance is how people who experience these states choose to describe them, and so their language will be reflected in my findings.

**Chapter outline**

In Chapter 1, I have introduced my topic, explained the inspiration behind it and wondered about the dearth of first person accounts of psychotherapy for psychosis. In Chapter 2, I outline my research methodology and describe my method. In Chapters 3 and 4, I present my findings regarding what has helped people with experience of psychosis therapeutically and what has hindered them. In Chapter 5, I discuss implications for clinical practice, with the hope that such findings may be of some benefit to the psychodynamic psychotherapy community.

## Chapter 2: Methodology and method

The methodology I have chosen is hermeneutic and the method is a literature review. I will explain my reasons for selecting this methodology and outline my experiences engaging with a hermeneutic approach.

### Hermes the interpreter

Hermeneutics means interpretation and is concerned with the art of understanding and making oneself understood (Zimmerman, 2015).
The word hermeneutics has its origins in Greek mythology, and is associated with Hermes, the winged messenger God. It was Hermes' role to relay potentially unclear messages from the Gods to mortals. In many ways he was the original translator, reminding us "that interpretation involves both grasping what someone has said (receiving a message) and making oneself understood (sending a message)", (Zimmerman, 2015, p.5). Viewing hermeneutics through this simple explanation, the parallel with the psychotherapeutic process is evident.

What particularly inspires me about a hermeneutic view of knowledge is the valuable role interpretation can play in therapy for psychosis. Zimmerman (2015) regards a hermeneutic approach as "the need for translation of difficult communications" and the "kind of interpretation that listen(s) for an important message or announcement of crucial importance" (p.5). Historically therapy for psychosis, with the exception of some psychoanalytic treatment, has not focused on interpreting or finding meaning within the client's own language (Garrett, 2019). My research findings reveal that interpretation, understanding and meaning making, within the safety of a secure therapeutic alliance, can be profoundly healing. I believe, in parallel with a hermeneutic approach, that if the therapist is open and genuinely values what the client has to say, as confusing or nonsensical as it may appear, meaning can be found.

### Finding the right fit

Hermeneutics was not the first methodology I considered. I originally explored a modified systematic literature review and began trawling PEP, PsychINFO

and PsychARTICLE databases using a variety of combinations of the search terms: ‘psychosis’, ‘schizophrenia’, ‘service user’, ‘client’, ‘analysand’, ‘psychotherapy’, ‘therapy’. However, I soon realised such a systematic search did not identify the important texts I was already aware of (due to my ongoing interest in the topic), many of these being autobiographies written by people who had experienced psychosis. This revelation corresponds with Boell & Cecez-Kecmanovic’s (2010) critique of systematic approaches which notes that databases are limited and a predefined set of keywords may miss relevant publications that could be found by using different terms (p.132).

I also agree with Boell & Cecez-Kecmanovic’s (2010) assertion that no literature review can be unbiased, complete and reproducible (p.130). I therefore wanted to use a methodology that allowed for more subjectivity and to focus on the texts I am drawn to and find most useful.

I then briefly considered doing a thematic analysis of a text that comprises various first person responses to psychotherapy for psychosis, but decided that focusing on one text felt too narrow. I wanted to discover what many people had to say about their psychotherapeutic experiences, not just a handful. The more structured coding process of thematic analysis also didn’t fit with the looser, more interpretative stance I wanted to take.

**Why hermeneutic**

From the beginning, my intention was to only include first person published accounts of therapy for psychosis. This is because I believe people with experience of psychosis have often not been listened to or have had their experiences interpreted through the unacknowledged bias of others.

Whilst I acknowledge the potential irony that I am writing this dissertation as a person who has not experienced psychosis, my hope is that by gathering first person published perspectives this process will provide a deeper understanding of the experience of psychodynamic psychotherapy for psychosis, in order to better inform therapy practice in this area.

I think it is important that I acknowledge my bias and therefore I have chosen a methodology that allows me the freedom to investigate texts of my choosing whilst also recognising any understanding I may find as a researcher is not "the truth" but a perspective. I am merely an interpreter of others' experiences, and as Smythe (2012) asserts, when I am able to recognise my own bias, new meanings and understandings are revealed. This approach fits nicely with the desired therapeutic standpoint. I am not the 'expert', and reflecting on Waddingham's (2016) critique of psychodynamic therapy, where she believes the therapist can hold an overly authoritative role, I believe it is necessary to remain mindful of this.

**The hermeneutic circle**

The process of hermeneutic research is a circular one. Reflecting Heidegger's belief that "self understanding and world understanding are inseparably interwoven" (Boell & Cecez-Kecmanovic, 2010, p.133), hermeneutics is concerned with how the parts impact the whole and vice versa. This means there is constant movement back and forth; how do the individual texts influence a wider understanding? How does a collective perspective reflect individual thought? Again, paralleling with the therapeutic process, where the therapist is listening on different levels, both to the individual narrative and the universal themes that the client's story is revealing.

The diagram below best illustrates the hermeneutic circular process I engaged in, of searching, sorting, selecting, acquiring, reading, identifying and refining.

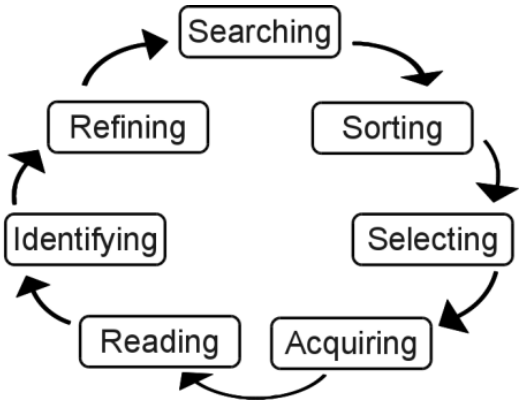

Figure 1: Hermeneutic circle of reviewing literature and techniques associated with different stages of the hermeneutic circle (Boell & Cecez-Kecmanovic, 2010, p.134)

Boell & Cecez-Kecmanovic (2010) believe it is preferable to identify a small set of highly relevant documents in the first iteration and my decision to only focus on first person accounts of psychotherapy for psychosis, disregarding third person case studies and minimal first person quotes, left me with a modest number of publications.

It took a lot of reading to get to this. I read over 50 publications and after I had excluded accounts that did not meet the parameters of psychodynamic psychotherapy, experiences that could not be described as psychotic, and texts where there was no substantial account of therapy, I was left with 15 texts. The majority of these texts are either autobiographies or first person accounts of therapy and psychosis published by the International Society for Psychological and Social Approaches to Psychosis' (ISPS).

A leading researcher in the field of psychosis and recovery, Davidson (2003), asserts that the few people with psychosis who write autobiographies are not representative of the majority of people with psychosis. He cites the 'YAVIS' critique of qualitative research, stating that autobiographies only relay the experiences of young, attractive, verbal, intelligent, successful adults, adding, "this should not be our first choice for a source of data about the lived experiences of people with schizophrenia" (p.28).

I disagree with this notion. I acknowledge my research findings represent a specific section of the population, and the writers are indeed verbal and intelligent, but this does not mean their experiences of psychosis are necessarily any different from someone who may be perceived (by a set of criteria held by the perceiver) as less intelligent. I'm also not sure why being successful detracts from their written experience. If anything, being successful enhances their ability to communicate. Eight of the 15 writers are trained as

psychologists or therapists and a further four are involved in mental health education proving they are perfectly placed to comment on best practice for psychosis. They are able to use their insight to educate those who do not have personal experience of psychosis.

However, whilst Davidson (2003) does not mention ethnicity, to the best of my knowledge all of the writers are white which represents a significant omission of experience. Varying cultural experiences of therapy for psychosis is an area I believe needs much more exploration and I will discuss this further in Chapter 5.

In terms of advantage, I also wonder if people who either seek or are offered psychodynamic psychotherapy for psychosis are in a more privileged place in society due to publicly funded mental health systems' preference for short-term talking therapy cures such as cognitive behavioural therapy (CBT) over the more lengthy and less 'measurable' psychodynamic approach (David, Cristea & Hoffman, 2018). In the United States, where mental health therapy is generally paid for via insurance policies, it would also follow that short-term behaviourally-based therapies are a cheaper option than long-term psychodynamic psychotherapy.

**The process**

After a lengthy period of reading, note taking, dismissing, discovering, swishing back and forth, I noticed a strong urge to create grids and tables, columns and rows. I realised I was trying to create structure, order and boundaries and I wondered if this desire for stability was a reaction to being continually immersed in other people's psychotic memories. Or perhaps, in the spirit of Bion (1997), I was trying to create homes for "stray" and "wild thoughts" (p.27) --concepts I did not yet fully understand and perhaps never would but needed containment (as opposed to constraint). When I had selected my 15 texts and housed them within a chart I finally felt a sense of clarity.

| Writer | Key literature source | Date pub. | Type |
|---|---|---|---|
| Barbara O'Brien (pseud) | Operators and things | 1975 | Autobiography |
| Annie Rogers | A shining affliction | 1995 | Autobiography |
| Ken Steele | The day the voices stopped | 2001 | Autobiography |
| Elyn Saks | The centre cannot hold | 2008 | Autobiography |
| Eleanor Longden | Learning from the voices in my head | 2013 | Autobiography |
| Anonymous (m) | Article American Journal Psychiatry | 1986 | Journal article |
| Rachel Waddingham | Article British Journal Psychotherapy | 2016 | Journal article |
| Catherine Penney | Beyond medication: therapeutic engagement and recovery from psychosis | 2009 | ISPS publication Ed. Garfield & Mackler |
| Joanne Greenberg | Beyond medication: therapeutic engagement and recovery from psychosis | 2009 | ISPS publication Ed. Garfield & Mackler |
| Jacqui Dillon | Experiencing psychosis: personal and professional perspectives | 2012 | ISPS publication Ed. Geekie |
| Patte Randall | Experiencing psychosis: personal and professional perspectives | 2012 | ISPS publication Ed. Geekie |
| Amhild Lauveng | Experiencing psychosis: personal and professional perspectives | 2012 | ISPS publication Ed. Geekie |
| Paul Newell-Reaves | Personal experiences psychological therapy for psychosis | 2019 | ISPS publication Ed. Taylor, Gianfrancesco & Fisher |
| Jeanette Woolthuis | Living with voices | 2009 | Hearing voices collation. Ed. Romme |
| Mien Sonnemans | Living with voices | 2009 | Hearing voices collation. Ed. Romme |

Figure 2: List of selected first person texts of psychotherapy for psychosis

Now I could stand back and assess how the parts related to the whole and vice versa. I noticed only three of the 15 writers were men, and one man was anonymous. I wondered why. Did this mean not as many men had therapy for psychosis as women? Did it mean that men were more afraid to be vulnerable? Did stories by women with psychosis fall into the 'mad woman'

literature fascination; not just the characters, Shakespeare's Ophelia and Bronte's Bertha Rochester, but the 'mad' writers themselves with their dramatic demises -- Virginia Woolf, Sylvia Plath, Anne Sexton?

I noticed the three male accounts did not state a believed cause or contributing factor to their psychosis compared to 11 of the 12 women. Again, I wondered, was this to do with fear of vulnerability? Or perhaps a belief that the origin of an issue is not important? I noted 10 of the 12 women had experienced significant trauma in childhood, six of these accounts involving sexual abuse. This discovery connects with Read & Cornwall's (2019) findings that people who have suffered one or more childhood adversities are nearly three times more likely to develop psychosis than non-abused people, and the greater the severity of the abuse, the greater the probability of psychosis (p. 676).

**Examining context**

The intention of this research is to understand what people with experience of psychosis have to say about their psychotherapy experiences, in particular, what helped and what hindered. The findings reveal there is much more written about what has helped than what has hindered, but this does not necessarily mean that psychodynamic therapy is a predominantly successful therapy for psychosis.

A key argument for taking a hermeneutic approach is the acknowledgement of context and a hermeneutic literature review calls for an analysis of how the environment influences the individual text and vice versa. Therefore it is crucial to understand the context of the opinions that I selected. Of the 15 texts, five are autobiographies, one is an independent research article, one is an article in a psychiatry journal and the remaining texts are contributions to psychology-based publications.

Three of the five autobiographies (Saks, 2008; Rogers,1995; O'Brien,1975) and the independent research article (Waddingham, 2016) provide the biggest criticism of psychodynamic-based therapies. The article in the American

Journal of Psychiatry (Anonymous,1986) focuses on only the successful components of the therapy, while the authors of the remaining texts tend to emphasise their positive therapy experiences over their negative ones.

A possible explanation for a pattern that emphasises the positives is to examine where the power lies behind the writing. For example, the autobiographies and research article are independently published whilst the account in the psychiatry journal is accompanied by an introduction making clear its editorial influence:

> Editor's Note: We present this paper as an unusual and powerful statement of the value of psychotherapy when used in conjunction with medication in the treatment of schizophrenia. The reader may be assured that the author's psychiatrist (with whom the author allowed us to consult) is fully in accord with its publication. (American Journal Psychiatry, 1986, p.68)

The remaining texts are either from ISPS publications or a collation of first person accounts about the experience of hearing voices (Romme, 2009). As with Anonymous (1986), the editorial influence upon content needs to be acknowledged. One text (Geekie, 2012) specifically asked contributors to outline what was both helpful and unhelpful about their experiences, whereas Romme's (2009) collation focuses on how different forms of therapy have benefited people who hear voices, meaning the therapy accounts described are predominantly positive.

**Emerging themes**

As I read and reread the texts, common themes began to emerge. Due to my previous work in researching helpful and hindering factors in recovery of psychosis, I was not surprised by people's common experiences. In accordance with many scholars in the field, I have always held the belief that 'psychotic ramblings' have meaning: it's about the therapist tuning in, and learning the person's specific language the best they can. So perhaps I pounced upon aspects of texts that conformed to my belief of the importance

of finding meaning. Likewise, as a therapist, I am aware of the power of the therapeutic alliance and, as I outlined in my encounter with Rhys, I have seen firsthand the healing that can occur when another person is accepted for who they are. Therefore I am grateful for the interpretative freedom a hermeneutic approach permits. In the following two chapters, I describe my findings of what I believe the writers perceive to be the most significant helpful and hindering factors of psychodynamic therapy for psychosis.

## Chapter 3: Findings - What helps

In this chapter, I describe the four main themes I have identified regarding what has therapeutically helped people with experience of psychosis. These themes are: the therapeutic alliance, finding meaning, creating safety, and exploring emotions. I acknowledge these findings are my interpretation of the writers' stories, and some of the writers themselves, if asked directly, might identify different themes. I also acknowledge I am using a large number of first person quotes. This is because I want to represent the writers' views in as unmitigated manner as I can to retain their original voice.

### Therapeutic alliance

The most 'helpful' element of psychotherapy identified by the writers is what I have chosen to term the therapeutic alliance. Not surprisingly 'therapeutic alliance' is not a term specifically used by the writers as it is a term mainly used by therapists. However the key factors they describe fit Bordin's (1979) definition of a therapeutic alliance, i.e. a collaborative relationship involving agreement of treatment goals and tasks as well as the development of a personal bond made up of reciprocal positive feelings (Ardito & Rabellino, 2011, p.2).

#### Partnership

Throughout the stories I have researched, it is the idea of partnership and the client being seen as an equal human being that stands out as a crucial therapeutic factor. This is not surprising given the prior negative experiences the vast majority of writers have encountered both in society and within the mental health system. Often their relationship with their therapist is the first time they have felt truly respected and accepted. Catherine Penney writes, "I do not remember much of this first meeting, only that Dr Dorman talked *to* me, not *at* me nor *down* to me" (Garfield & Mackler, 2009, p.147).

Arnhild Lauveng (2012) also notes that a more equal power balance enabled her to bond with her therapist, writing, "Some of what made me trust him was that he never used more power than he had to" (p.79).

This theme of partnership or alliance runs through the first person accounts. Joanne Greenberg writes that her therapist was open from the beginning that they needed to work together for healing to occur. She describes her therapist as always looking upon them as partners, “and not unequal partners in the process. I have said before that we were miners in a shaft mine…I had the map; she had the light” (Garfield & Mackler, 2009, p.156).

Elyn Saks (2008) also emphasises the importance of an equal relationship, referring to herself and her therapist as making “a good team” (p.246).

Annie Rogers (1995) describes her relationship with her therapist as a two-way process that requires resilience and patience by both parties. She writes of their reciprocal frustrations whilst acknowledging their pursuit of a mutual goal, “but we are patient with each other because we both share the same wish” (p.171).

A psychodynamic approach places great importance on the relationship between client and therapist, believing that common relational patterns reveal themselves within the transference, making it fertile ground to heal past wounds and create a new way of relating. Anonymous (1986) acknowledges originally feeling confused by his therapist’s focus upon their relationship. He writes:

> His persistence in talking about “us” made me curious and later made me feel, despite a twinge of guilt, that maybe it would be nice to talk about “us”. The guilt came from the fact that there *was* an “us”. For so long it had been “me” and “them”. (p.69)

**Being real**

It is not uncommon for people with psychosis to feel confused about their identity and to wonder if they are actually a real person. Lauveng (2012) believes that questioning her identity was the main warning sign that she was becoming unwell. She describes how the “safety of knowing that I was an “I” – was starting to crumble. I became increasingly insecure about whether or not I

really existed, or if I was only a character in a book or a being someone made up” (p.5).

Saks (2007) writes of having a constant awareness of being different, “some sort of alien, not really human. Other people have flesh and bones, and insides made of organs and healthy living tissue”. Instead she viewed herself as “only a machine, with insides made of metal” (p.193). Therefore the sense of being ‘seen’ and fully accepted by another person can be extraordinarily healing.

Writes Jacqui Dillon, “having an empathic witness who was willing to hear and see my suffering made me feel real and, for the first time, as if I mattered” (Geekie, 2012, p.19). This sentiment is echoed by Annie Roger’s (1995) observation that her therapist “listens to me as if I am not only creditable, but an extraordinarily trustworthy narrator, a "true 'I" (p.157).

Elyn Saks (2007) credits the trusting relationship she has with her therapist to her re-emergence as a true human being able to interact with others. She notes that other people were, “no longer a faceless, threatening mass, existing only to judge or possibly harm me – they were becoming individual persons - human beings, as I was – vulnerable and interesting – I began to move back into the world again” (p.94).

Anonymous (1986) comments, “I often felt at odds with my therapist until I could see that he was a real person and he related to me and I to him, not only as a patient and therapist, but as human beings. Eventually I began to feel that I too was a person, not just an outsider looking in at the world” (p.70)

**Not just a diagnosis**

The sense of being seen as a valid human being rather than a diagnosis is a consistent theme throughout the first person accounts. Arnhild Lauveng (Geekie, 2012) writes that being told she was a “chronic schizophrenic” (p.85) and given behavioural therapy was vastly unhelpful in contrast to being

“treated as a unique human being, worthy of being alive and worthy of good experiences” (p.85).

Eleanor Longden (2013) comments that a key factor of her successful therapy experience was that the therapist was “far more interested in me as a person than as a diagnosis”, forging a meaningful relationship with her that honoured her strengths, abilities, inherent worth and humanity, and her capacity to heal. Catherine Penney notes that in the eight years of her therapy she was “never treated as a diagnosis” (Garfield & Mackler, 2009, p.154). Ken Steele recounts of his first meeting with his therapist: “I felt that I entered her place as a guest, not a client – she was clearly interested in me, and I felt myself about to succumb to her caring” (Steele & Berman, 2001, p.188).

**Stability and commitment**

An important element of any relationship is the ability to survive what psychotherapists often refer to as ‘rupture and repair’: a conflict between two people that is resolved. A common psychodynamic view is that the survival of rupture and repair events can strengthen the therapeutic alliance as well as provide new relational opportunities between therapist and client (Haskayne, Larkin & Hirschfeld, 2014).

Several of the first person accounts detail therapeutic incidents of rupture and repair and note the lasting benefits of surviving such a phenomenon, often for the first time. Paul Newell-Reaves describes an incident early in therapy when he angrily exited the room, deciding to return ten minutes later. He reports that his therapist expressed gratitude and possibly relief at his return, causing Newell-Reaves to view the event as a major turning point in their relationship. He believes the occurrence brought focus to both of their limits and their reaction to the pushing of those limits, and concludes, “soon after, the hard work began” (Taylor et al, 2019, p.98).

Elyn Saks (2007) also describes a major rupture with her therapist that involved Saks refusing to leave her therapist’s house. Despite the drama that unfolded, her therapist continued to see her and Saks writes of her relief that

her therapist did not recoil from her as many people had before. When the therapy eventually ended due to her therapist's retirement, Saks reflects how her therapist was "the person who tolerated all the bad and evil that lay within me, and never judged. She was my translator, in a world where I felt most often like an alien" (p.115).

Catherine Penney's relationship with her therapist is another example of client and therapist weathering substantial storms. Despite the terror of hearing voices that told her to kill her therapist, Penney continued her therapy, further testing the relationship with suicide attempts when her therapist was on holiday or generally unable to see her. Her therapist remained committed to their alliance, which Penney describes as a crucial element of her recovery, commenting, "(he) believed in my wholeness and capacity to heal even when no one else did" (Garfield & Mackler, 2009, p.154).

Ken Steele (2001) describes leaving his therapist with no warning and then realising he wanted to return - something he had never voluntarily done before. His therapist was initially sceptical about accepting him back. When she asked him why he returned, he reflects:

> The only reason I could give her, let alone myself, was that the "heart" of the place that I felt from my first visit had actually been strong enough to overcome the wishes and expressed commands of the schizophrenic voices that had been with me since the age of fourteen. "I'm not sure that I'll be able to resist them and stay this time," I said. "The best I can do is promise to try. Please, I'd like a second chance." (p.192)

**Finding meaning**

A second key theme which emerged from my research regarding what is helpful for therapy for psychosis is finding meaning: this involves the therapist both interpreting and validating the client's experiences. In Chapter 2 I referred to the connection between a hermeneutic methodology, that searches for meaning and context, and the importance of interpretation within

therapy for psychosis. I also commented that finding meaning within psychotic language and behaviour has not been a common treatment approach. This is mainly due to a dominant medical belief that psychosis is a biologically-based illness that requires a biologically-based cure, i.e. antipsychotic medication (Read, 2004). However, as is evident in the writers' testimonies to come, there are therapists who take a 'making meaning' approach to psychosis, and the efficacy of such an approach is clear.

**Psychosis as a defence**

A common psychodynamic view of psychotic behaviour is that psychosis serves to protect the person from painful thoughts and feelings; that the unconscious mind is defending the conscious mind (Saks, 2007). Barbara O'Brien (1975) believes it was her therapist's faith in the unconscious that caused him to be open-minded about her symptoms and to believe in her recovery, when others hadn't. She writes:

> It was all perfectly clear to the analyst. When schizophrenia had struck, my unconscious had taken over. It had guided me while my mind had been shattered, had even probably aided in the mental repair. It had sensed an approaching recovery and had steered me quickly to a doctor's office where, when my voices left me, I would discover that insanity, not Operators, had overwhelmed me, and where I could cling, with my clouded mind, to a new anchor until the repair work was finished. What I must remember was that my unconscious was a friend, a real friend. (p.93)

The view that psychotic behaviour is a type of defence is also of comfort to Elyn Saks. After a classmate receives high praise from a lecturer, Saks thinks that people are trying to kill her. Her therapist wonders if this is a defence against feeling competitive, and that rather than feel negative feelings towards someone else, she chooses to feel attacked instead. Saks expresses her relief that her experiences have meaning as well as having the opportunity to voice her thoughts, commenting, "A lot of therapists have a rule where their

patients cannot articulate their delusions or hallucinations — but to me you need to have a place where you can do that, where it's safe" (Dvorsky, 2013).

**Survival strategy**

Other writers discuss a sense of reassurance that there is meaning behind their psychotic symptoms. Jacqui Dillon writes that her therapist's belief that her "so-called symptoms were in fact creative, life saving strategies that made absolute sense" (Geekie, 2012, p.18) guided their work together. She reports feeling a tremendous sense of relief that her streams of consciousness that felt disconnected and confused would be met with understanding.

Eleanor Longden (2013) writes of how important it was for her recovery when her therapist viewed the voices she heard as a meaningful response to distressing events. By seeing her experiences not as symptoms but as adaptations and survival strategies, she was able to put context to her suffering and heal from past abuses.

Catherine Penney's therapist also reframed her symptoms (such as keeping her eyes closed for two years) as a normal reaction for someone who, for survival purposes, had shut themselves down mentally, emotionally and physically (Garfield & Mackler, 2009, p.152). This reassurance paved the way for a slow but consistent recovery.

**Another way of communicating**

Both Jeanette Woothuis' and Mien Sonneman's (Romme, 2009) therapists took an investigative approach to the voices they hear, asking what they are saying and looking for meaning within their words. Having another person interested in the content of their voices enables Woothuis and Sonneman to understand the voices better and decide how to best approach the experience, in Woothuis' case to examine the emotions contained in the voices and in Sonneman's case to ignore the voices completely.

Annie Rogers' therapist views the 'gibberish' she speaks as a valid language identifying the underlying themes of love and abandonment. Rogers (1995)

writes, “He knew that “gibberish” was a language and he trusted my voices” (p.127). Her experience with her therapist is the first time she has felt truly listened to and her relief expresses itself physically -- she reports, “After seeing him, I could sleep” (p.127).

**Creating safety**

A third key finding regarding what is helpful for therapy for psychosis is the creation of safety, not just in the therapeutic space, but also in the client’s general environment.

In some situations the client and therapist are dealing with safety at its primal level. Due to feeling immense fear, Catherine Penney did not speak nor look at her therapist for six months. For her, the turning point was when her therapist acknowledged the world can be a scary place, and commented she must feel safe “in there” (Garfield & Mackler, 2009, p.148), referring to what she describes as her catatonic posturing and rocking. Penney reports, “An antenna went up. How did he know? That was the beginning. Although I did not show any outward signs of change or improvement, and would not for two and half years, the seed had been planted” (Garfield & Mackler, 2009, p.148). The therapist’s comment is also an example of meaning making and therefore validation as he sought to understand the motivation behind her behaviour.

Having survived an extremely abusive childhood, Jacqui Dillon’s need for safety in the therapy room and beyond was paramount to her healing. Her therapist was clear that she (Dillon) was in charge of the process as too many things had already happened to her that were beyond her control. She describes the therapy room as the first place where she began to have some sense of feeling safe due to the strength of a respectful and patient therapeutic alliance. (Geekie, 2012, p.19). She also notes strategies that enabled her to feel safe outside of the therapy room, such as the use of a transitional object and creating a safe space in her house with cushions, blankets and soft toys.

Eleanor Longden's therapist suggested similar strategies: Longden made a safe space in her home and promised herself it would be the one place she would not self-harm. She concentrated on self soothing, massage, warm baths, calm music and also came up with creative safety strategies, such as creating fake wounds with theatrical make up as harmless simulations of real ones (Longden, 2013). She also used mindfulness and grounding techniques to help her get back into the body instead of spending too much time in her head (Geekie, 2012, p.186).

Paul Newell-Reaves describes his therapist deviating from a classical psychodynamic approach to incorporate visualisation techniques into his treatment. This involved him visualising a walled fortress around himself and physically bringing his fists together when visualising the gates closing. He writes, "Not only did this technique strengthen my emotional boundaries in the moment, it began to build up my interpersonal boundaries more substantially" (Taylor et al, 2019, p.99).

**Exploring emotions**

The fourth key theme regarding what is helpful for therapy for psychosis is identifying and feeling emotions. Jeanette Woolthuis writes how she didn't know what her feelings were anymore and what belonged to her voices and what belonged to others. She describes how she learned to link the voices she heard with repressed emotion, and through her therapist's tolerance, she was able to feel that emotions were her own and allowed to be there. Her therapist asked why he was not seeing her anger when she had so much to be angry about, causing her to realise how much she feared her emotions, particularly anger and its destructive power. She learned to both accept and safely express her anger, commenting, "I discovered that if I felt an emotion I wasn't going to die. I could stay inside my body and I could keep on living" (Romme, 2009, p.207).

Jacqui Dillon reports a similar revelation, in terms of the connection between her voices and shut-off emotions. She describes how healing it was when she realised her voices were disowned selves, and began to work collaboratively

with them, listening to the emotions they were conveying. She writes, “By listening to their despair it didn’t make matters worse as I had initially feared, but actually helped them and me to feel calmer, less alone and less suicidal” (Geekie, 2012, p.20)

Armhild Lauveng credits her therapist with helping her explore emotions that she initially had very little understanding of. By offering suggestions of what she may be feeling, she effectively learned ‘emotional literacy’ in a setting that felt safe enough to explore her feelings. She writes of her joy in discovering she could feel all different kinds of emotions and still be herself: “I can be kind or difficult, happy scared, angry or loving. But through all my emotional and behavioural changes I am myself. Always.” (Geekie, 2012, p.85).

Paul Newell-Reaves also views learning how to feel and process his emotions as a major part of his recovery. When identifying a troubling emotion or experience, his therapist suggested he stay with that emotion - to feel it fully and process it to enable an easing of the feeling in the future. Newell-Reaves observes that, “Staying with these emotions feels like an important part of the catharsis that comes from our sessions” (Taylor et al, 2019, p.99).

Ken Steele (2001) writes of how important it was for him to finally acknowledge his feelings. He comments how his therapist, “helped me confront my feelings about my family: my mother's coldness, the knowledge that I had disappointed my father, the birth of a "replacement" when I was fifteen” (p.202). He acknowledges that striving to come to terms with his story was hard and painful, but also ultimately healing.

**Summary**

I believe the four prominent themes identified: the therapeutic alliance, finding meaning, creating safety and exploring emotions, provide useful data not only for therapists working with people with psychosis, but for people who experience psychotic symptoms. To hear what has helped others psychotherapeutically can empower clients to take more control of their

treatment, and request ways of working and focus that may not originally be proposed by their therapist.

## Chapter 4: Findings - What hinders

In this chapter, I describe the three main themes I have identified regarding what has therapeutically hindered people with experience of psychosis. These themes are: fixed therapeutic beliefs and treatment that led to a denial of the client's experience; unethical practice; and breaks in therapy.

### Fixed therapeutic beliefs and treatment leading to denial of experience

The most prominent theme in the writers' descriptions of what hindered therapy is having a therapist with fixed beliefs and a narrow treatment focus which does not allow for the client to feel truly heard and treated as an individual human being. Being treated as unreliable narrators with invalid experiences compounds the clients' sense of unworthiness and lack of autonomy.

#### Fixed beliefs

Annie Rogers (1995) describes in detail the breakdown of her first significant therapeutic relationship. The alliance began when her therapist, Melanie, was a psychotherapy student, and after some major boundary violations from Melanie (which I will discuss further in the chapter) Rogers started seeing another therapist, Blumenfeld. Much of Rogers' and Blumenfeld's work together was concerned with Rogers understanding and healing from her relationship with Melanie, and at one point, Blumenfeld acted as a mediator between the two. Blumenfeld asked Melanie if she thought she knew what Rogers needed better than Rogers knew herself, and Melanie replied that yes she did, as she was Rogers' therapist and she had to know. Rogers (1995) reflects:

> I see suddenly, very clearly, that her trust in me changed as she acquired more and more clinical training and experience, until I felt, in the last year we met, that what I said to her hardly mattered. She had her interpretations all ready, and my words were fitted to them. Anything that did not fit could be attributed to my "denial" or "resistance". (p.271)

Barbara O'Brien (1975) recounts a similar experience of feeling as if her therapist believed more in his psychological theories than in her as a person. She reports how her therapist would commend 'the unconscious' rather than her as an individual, his separation of the two leaving her feeling dismissed. She also describes, with wry humour, her therapist's belief that her schizophrenia was caused by an insufficient sex life. She writes:

> The analyst, besides being a Frenchman, was a Freudian. Freudians, I decided later, had much in common with small religious cults, possessed with tight little worlds of ideas, which built little matchstick kingdoms on a wide plateau of truth before claiming the plateau. To the analyst, any breakdown in mental or emotional machinery could be traced only to one cause. A sex life that was not sufficiently full. (p.95)

Rachel Waddingham (2016) also questions the helpfulness of applying fixed theories to individual circumstances. She comments that she sometimes hears psychodynamic therapists speak about concepts, "with a sense of certainty and belief that begins to move them from potentially useful abstract concepts into the world of the concrete and the absolute" and wonders about the effect of imposing an interpretation of a person's difficulties from an expert position (p.275). She describes her concern of not being heard and having her experiences stolen from her and made her therapist's own.

Arnhild Lauveng (2012) recounts an experience with a therapist who responded to her distress by drawing Freudian circles of id, ego and superego. She writes, "I didn't understand this at all, but it made me quite sure that *he* didn't understand anything of what I was trying to say" (p.6). She didn't return.

Paul Newell-Reaves describes his frustration when his therapist was insistent about issues that Newell-Reaves himself dismissed, for example that he might have jealous feelings towards his sister, who was succeeding in her career. Newell-Reaves writes, "I have repeatedly rejected that idea; I am simply not a jealous person, and I would also hate doing her job. Eventually, I got annoyed

and asked him to stop bringing it up" (Taylor et al, 2019, p.102). Newell-Reaves goes on to describe that the therapist honoured his request, which I believe is an example of the therapist showing respect for Newell-Reaves' perspective.

Whilst a diagnosis can be tentative or used as a working hypothesis, a diagnosis can also represent a fixed belief or theory, and Elyn Saks (2007) describes how destructive it was for her to be given a diagnosis of 'schizoaffective disorder, depressive type'. She writes, "Seeing those words – coming from someone I knew, someone whose clinical judgment I couldn't dispute – felt like death. And so, as if to fully inhabit the diagnosis, I quickly started to unravel" (p.221).

**Fixed approach**

Having a fixed therapeutic approach that is not adapted to the client's needs is also viewed as problematic. Arnhild Lauveng describes how her first therapist was passive in sessions, allowing Lauveng to take charge and decide the direction they would proceed in. Whereas this may seem an empowering stance it had the opposite effect. Lauveng (2012) writes:

> The problem was that I mostly just became lost and wound up in very tiresome and treacherous places - I didn't want a therapist who followed me while I was getting lost and who afterward explained the bad result with a serious diagnosis. I wanted a therapist who actively helped me see what I was doing and who could show me alternatives that were more appropriate to cope with my condition. (p.34)

Rachel Waddingham (2016) describes a similar experience of not feeling safe when the therapist takes a non-responsive approach. She explains how a therapist's passive façade echoed her childhood abuse that was perpetrated by people concealing their true selves. This experience in itself is potentially re-traumatising and she emphasises her need for therapists to be "willing to step out of the 'usual' practice and engage with me, explicitly, as a fellow human" (p.275).

Elyn Saks (2007) describes her shock at her therapist's refusal to comply when she asked him to change some of the ways in which he was working with her - such as no longer threatening to terminate their sessions and allowing her to move around the room and cover her face with her hands. His firm belief in his actions and his unwillingness to negotiate caused her to end therapy with him. She writes of her feelings of rejection and betrayal, adding, "why I didn't end up hospitalized as a result of the upheaval, I don't know to this day" (p.324).

**Narrow treatment focus**

The idea of requiring therapy to respond to their needs as a client rather than to fit in to a narrow therapeutic model is reflected in both Patte Randal's and Eleanor Longden's critique of their therapy experiences. Randal notes that her therapists never showed any interest in her spiritual history and her need to explore her spiritual and cultural heritage, despite the fact many of her psychotic symptoms were connected to spiritual beliefs. Now qualified as a psychiatric medical officer herself, Randal views her so-called psychotic experiences as a "spiritual emergency", and believes finding the emerging narrative of spiritual meaning-making (which she did without a therapist) crucial to her recovery (Geekie, 2012, p.65).

Eleanor Longden expresses her frustration at only being offered language-based therapeutic interventions when the idea of talking terrified her. She writes, "I remember a helpless sense of 'How do I express the inexpressible?' How do I talk about my fear, when to articulate that I'm afraid is, in itself, frightening?" (Geekie, 2012, p.185). She describes her gratitude in finding a therapist who was supportive of her using non-verbal strategies, such as mindfulness and grounding techniques.

These non-typical psychodynamic therapy strategies connect to the significance of creating safety in Chapter 3, where Jacqui Dillon and Paul Newell-Reaves write of their appreciation of their therapists' incorporating non-verbal techniques into their treatment. I believe this is an important

implication for best practice for psychosis that I will discuss in more detail in the following chapter.

**Denial of experience**

It follows that having fixed beliefs and a narrow treatment focus means experiences that don't fit with that belief are denied. As mentioned in Chapter 3, one of the most helpful elements of therapy for psychosis is the client feeling truly heard and respected. Therefore it makes sense that the converse, not feeling believed, is a significantly hindering component of therapeutic experiences.

Rachel Waddingham (2016) recounts how unhelpful it was when her therapist labeled her voices 'non-relational' and told her it would be better if she could lock them up so they didn't interfere with her therapy (p.277). Arnhild Lauveng describes her feelings of fear and confusion when therapists told her that her hallucinations were not real and were just a sign she was sick. She compares the response to other therapists who were genuinely interested in hearing what she saw whilst also informing her their experience was somewhat different to hers (Geekie, 2012). She also recounts her frustration in being told that her dream to become a psychologist (which she has since achieved) was a symptom of over identifying with her therapist. Lauveng (2012) writes, "And it hurt; it hurt unnecessarily, and I think that even though they didn't believe me, this was a pain they didn't have to inflict on me" (p.77).

Longden describes her exasperation in being told by others what she was feeling, rather than having her own account taken seriously. She writes, "exposure to well-meaning yet overbearing and arbitrary assessments of my emotional state was infuriating, disorientating and deeply disempowering" (Geekie, 2012, p.185).

Barbara O'Brien (1975) describes a tumultuous relationship with her therapist who frequently became frustrated with her when her experience does not match his interpretation. She recounts his anger when she is not able to tell him what she is thinking:

> “Don't tell me there's nothing going on in your mind," the analyst stormed at me. But there was nothing at all going on in my mind. The analyst fretted and fumed as if he knew perfectly well that there was plenty going on under the sandy shore and he was going to bully until it came out. (p.84)

**Unethical practice**

To practise ethically as a psychotherapist is to adhere to the professional body’s Code of Ethics and its values of respect, integrity and fairness (PBANZ, 2013). This includes maintaining boundaries and recognising the power imbalance inherent in the therapist-client relationship. While it is not surprising that unethical practice is therapeutically hindering, it is concerning that such practice occurs at all. What I find most disturbing is the unethical behavior occurs because the therapist seems to be convinced their actions are justified.

The most significant example of unethical practice is the boundary violations that occur within Annie Rogers’ relationship with her student therapist, Melanie. Melanie invites Rogers to her house for dinner and to meet her daughter with the idea of having Rogers live with them for a while. At the next session she tells Rogers she has changed her mind and accuses Rogers of having seduced her. When Rogers tries to smash a window in anger, Melanie slaps her across the face and terminates therapy. The confusion of this experience triggers Rogers to have a serious psychotic episode and much of the book is about her gaining understanding and healing from this relationship. She discovers that the failure of her relationship with Melanie is not an uncommon story, commenting:

> It is ironic and heartbreaking to hear again and again how therapists took creative risks, which became seductive and false promises, and how, in the end, when they abandoned their patients, they used the language of clinical practice to step away from any real responsibility for those abandonments. (Rogers, A.,1995, p.318)

Rogers' sentiment is echoed by Rachel Waddingham's critique of some of her own psychodynamic psychotherapy experiences. She describes an incident where her therapist fell asleep during the session and blamed it on the heaviness of her dissociation. When she mentions this event to other psychodynamic therapists she is shocked they hold a similar view, believing she and her unconscious processes are to blame. Waddingham (2016) expresses her concern about the dangerousness of such practice, writing, "If we are not able to see the harm that can be caused by therapists, if we use our theories and expertise to explain away intensely difficult topics, how can one ever honestly say this profession is safe?" (p. 277).

From Waddingham's testimony of her experiences, what appears to have been neglected is a space for wondering and reflection around unconscious processes. It feels as if in this mode of practising that unconscious processes are used definitively as 'facts', which is not possible as we can only hypothesise (otherwise it would not be unconscious).

While what Waddingham describes may not be viewed as unethical practice as clearly as the boundary violations Rogers' experienced, I believe a therapist failing to acknowledge and explore their own role in the breakdown of a therapeutic relationship is unethical, as it reveals a dangerous absence of professional responsibility, and I would have questions around what would be inhibiting this exploration.

Rogers (1995), who is now a professor of psychoanalysis and clinical psychology, recognises the damage such beliefs can wreak:

> In practice, if we are uncomfortable, or truly frightened, we have a tendency to blame our patients, and we have concepts readily at hand to effectively squelch any doubts about our assessment. Yet, in the act of defending ourselves, we are most likely to pass on our deepest wounding to our patients. (p.319)

**Breaks/premature endings in therapy**

The final theme identified as hindering therapy are breaks or premature endings in the therapy relationship. The effect of such a break is not

surprising due to the intensity of the client/therapist relationship, which as mentioned in Chapter 2, is often the first positively significant relationship the client has experienced. Elyn Saks (2007) describes her desolation when she discovered her therapist is retiring in three months' time. She writes, "As though someone had hit a switch, I was almost immediately in terrible shape – I was surrounded by destructive energy and unspeakable fear" (p.227). She recovers quickly when her therapist delays his retirement but believes she would have been hospitalised had the delay not occurred. She makes the point that therapeutic endings need to occur organically, when both client and therapist agree the process has reached its closing. She acknowledges her therapy will one day come to an end, adding, "But for me to stay sane, our "end" had to come at the right time and place" (p.231).

Catherine Penney describes her immense distress when she hears a rumour her therapist is leaving, and is determined to kill herself. Similar to Elyn Saks' situation, the ending does not occur, as her therapist has her transferred to his new practice. Their therapeutic relationship eventually ends, but, again similar to Saks' view, at the correct time, when they both agree enough work has been done.

Early on in the therapeutic relationship Penney also struggles when her therapist is on holiday, attempting suicide in her distress. Paul Newell-Reaves describes feeling a less extreme sense of abandonment when his therapist is on holiday, writing that without the structure of his twice weekly sessions he slips back into old habits of non-functionality, and that it takes several session for him to rebound from the void (Taylor et al, 2019, p.102).

**Summary**

As I mentioned whilst addressing context in Chapter 2, the writings reveal significantly more positive accounts of psychodynamic therapy for psychosis than negative. However this does not detract from the damage that can occur when therapists' fixed beliefs deny the client's experience and at worst, overshadow their ethical judgment. Whilst breaks and endings in therapy are a necessity, the writings reveal it is important both parties be mindful of the negative impact such changes can have.

## Chapter 5: Implications for practice

In this chapter I identify the strengths and limitations of the research study, and discuss implications of the findings in regards to psychotherapy practice, research and theory.

### Discussion

My intention has been to discover what people with experience of psychosis have to say about their psychodynamic therapy encounters: what has been helpful? What has not? And what can we as therapists learn from these accounts? I selected fifteen writers who describe their experiences in first person, and identified four prominent helpful factors: the therapeutic alliance, finding meaning, creating safety and exploring emotions. I also identified three key hindering elements: the therapist holding fixed beliefs that lead to a denial of the clients' experience, unethical practice and breaks in therapy.

### Strengths and limitations

I believe one strength of the study is the use of first person voices selected from sources that are either independently published (i.e. autobiographies) or contributions to clinical psychological texts that allow the writer to express their view as a coherent chapter or article. I have mindfully included many first person quotes in order to represent the writers as authentically as possible. I see this as a strength because I have discovered how rare these first person accounts are. I believe gathering these voices together edify the collective themes, and make them more accessible to those interested in suggested client-based best practice.

Another strength of the study is many of the writers are trained therapists and therefore able to walk in both worlds: that of the client and the therapist. My motivation for researching this topic is to discover how I can best work in a psychodynamic way with clients with psychosis, and I have found such writers' abilities to think from both perspectives invaluable. I firmly believe that 'lived experience of psychosis' clinical training would greatly benefit

psychotherapists and this is a topic I will discuss in more detail later in this chapter.

A significant limitation of the study is the overall paucity of first person accounts of psychotherapy for psychosis. In Chapter 1 I wondered why there is such a silence, despite researchers acknowledging the benefit of lived experience perspectives. On a broad level, I believe the absence can be attributed to the fear and distrust psychotic experiences can evoke. As the writers have described, the experience of psychosis can be extremely frightening, not just for the person experiencing it but also for the people around them. However, the therapists who the writers worked positively with seemed able to move towards the experience, not away from it. This does not mean that the therapists did not feel fearful at times, but that they had a capacity to both acknowledge and contain their fear.

**Attitude towards psychosis**

Arnhild Lauveng, one of the referenced writers, who later trained as a clinical psychologist specialising in the treatment of psychosis, comments, “Benedetti (1964) states that psychotherapy for psychoses involves a certain attitude, not a certain technique, and so the important thing is not only *what* you do, but *how* you do it.” (Geekie, 2012, p.85).

Her comment has caused me to reflect on the importance of ‘attitude’ and by attitude, I mean not just how the therapist feels about the client, but how do therapists feel about working with psychotic phenomena? Whilst ‘attitude to psychosis’ is not technically one of the four main themes identified regarding what is helpful treatment for psychosis, it is probably best represented in the theme of ‘finding meaning’, where therapists show a genuine curiosity and desire to understand and support their client’s experiences.

I have had conversations with therapists who have referred to the experience of psychosis disparagingly, as ‘crazy’ and ‘mad’, and I wonder how they can hide such an attitude from a client. Given the writers’ assertion that the therapeutic alliance and being regarded as an equal is critical to their

recovery, the client might surely intuit their therapist's attitude. I also wonder what is behind the therapist's resistance: are they afraid that in seeking to understand psychotic experience they will in turn exacerbate the client's psychosis, as if by accepting their client's experience they are encouraging it? Therefore I believe 'attitude to psychosis' is an important issue for any therapist working with psychosis to consider. Are they genuinely interested in the client's experience, do they genuinely hold an open mind? Do they genuinely respect their client's opinion? What helps and supports a therapist to work with psychotic experience with curiosity?

Egan Bidois is an advocate for a hauora (holistic) Māori approach to psychosis, who rejects his psychosis diagnosis and identifies as a voice hearer and seer, similar to many of his tupuna (ancestors). I very much wanted to include Egan Bidois' (Geekie, 2012) writing as a core text but because it does not provide an account of therapy it did not meet the criteria. However he makes the following comment that connects with a key factor identified as hindering therapy for psychosis: the therapist holding fixed beliefs that deny the client's experience. He writes:

> To me how I make sense of my psychosis isn't important – as I made sense of and solace with it many years ago. It's how do *you* make sense of it that is the crunch. Are my experiences psychosis? Are they hallucinatory? Are they delusional and/or grandiose? What do your life, your learning and your culture provide by way of an answer? (Geekie, 2012, p.41)

**Lack of cultural diversity**

Bidois' questioning segues into another significant weakness of this research study: its lack of cultural diversity. As I mentioned in Chapter 2, to the best of my knowledge all of the writers I have referenced in this study are white. I hoped for a range of cultural perspectives but the specific criteria of first person accounts of psychodynamic therapy for psychosis prevented this. Whilst Egan Bidois (Geekie, 2012), who is Māori, and Esme Wang (2019), who is Taiwanese American, both refer to having had therapy, they do not

describe their experiences. Other texts identified as describing cultural approaches to psychoses do not provide first person accounts (Gleeson, Killackey & Krstev, 2008; Alanen et al, 2009).

Due to previous studies I have undertaken regarding cultural perspectives of psychodynamic psychotherapy, I am not surprised at the dearth of first person multicultural accounts. Historically, psychotherapy, in particular psychodynamic psychotherapy, has been based on Western ideas of individualism, and much has been written on its historical failure to recognise cultural difference and incorporate a collectivist view (Leary,1997; Dalal, 2002; Ahad, 2010).

Providing a New Zealand perspective, Morice (Ngāti Porou) believes the restrained style of psychotherapy is in conflict with Māori values. She writes, “Kaupapa Māori theory is strongly opposed to the ideas of neutrality, detachment and objectivity, all of which are regarded as Eurocentric, arrogant and ultimately destructive” (2003, p.5).

Psychotherapy that fails to hold open the space for questioning and wondering would arguably be at complete odds with Kaupapa Māori theory. It is my belief that Kaupapa Māori philosophy would have much to offer psychotherapy for psychosis as its perspectives are more in line with my findings on what was helpful, essentially working in partnership and being open to the client’s experiences, which I expand upon further in the chapter.

## Implications of findings

### Participatory research

My decision not to include case studies or first person quotes from research studies that were not led by people with experience of psychosis has understandably limited my findings. In Chapter 1, I refer to a study by Bjornestad et al (2018) that surveyed peoples’ opinions of their psychotherapy for psychosis. Whilst I support such research, I wondered how much more

efficacious the study would have been if it had been conducted by researchers with lived experience of psychosis themselves.

I believe a possible remedy for the lack of first person perspectives could involve the use of a participatory research methodology, where at all stages the researchers themselves are mental health service users. Based on an approach first designed for local communities in developing countries, the intention is to ensure that community members have ownership of the project by being involved directly in the research process.

Rose et al (2011), researchers based in the United Kingdom, adapted the model for the mental health sector having recognised that conventionally derived outcome measures are problematic because the methodology and outcome is framed from the perspectives of clinicians and researchers (p.41). They argue all large-scale studies should follow a participatory model because “it is mental health service users who know from the inside what treatments and services benefit them and which are detrimental” (p.46).

In terms of ongoing research, I believe a qualitative study, conducted by people with experience of psychosis, expanding on the themes of what has helped and hindered psychodynamic therapy, would greatly benefit not just the psychotherapy community, but health practitioners in general.

**Lived experience training**

In Chapter 2, I discussed how Hermes was the original translator, able to relay potentially confusing messages from the Gods to the mortals. I believe people with experience of psychosis are the most effective translators of their experience, the best ‘Hermes’, and therefore the most compelling teachers. Following their most severe experiences of psychosis, 12 of the 15 writers became formally involved in the mental health sector, as psychologists, therapists and educators. I believe it would be very helpful for psychotherapists to have the opportunity to learn from lived experience practitioners.

Debra Lampshire, who has a history of psychosis, is a senior tutor with The University of Auckland's Centre for Mental Health Research and Policy Development. Part of her role involves tutoring nursing students and providing a first person perspective of psychosis. Research studies have proven how efficacious her role is: how she has normalised experiences which many find fearful and strengthened peoples' belief in the recovery process (Schneebeli, O'Brien, Lampshire & Hamer, 2010).

A similar international research study has identified that incorporating people with experience of mental illness, referred to as "EBE – Experts by Experience" into medical training is a catalyst for students reflecting on the views and attitudes they hold (Happell, Waks, Bocking et al., 2019, p.235). The study shows that attitudes can be changed through hearing firsthand from people with experience of psychosis, in particular challenging some students' assumption that people with experience of mental illness cannot offer anything of academic value. The study also found how effective the description of experiences through story telling can be, referring to the relaying of personal stories as "a very powerful tool" (Happell et al, p.239) to aid students' understanding.

Both findings - the importance of reflection, and the effectiveness of storytelling as a means of communication - offer ways forward for therapists to greater engage with the experience of psychosis. I believe the success of Lampshire's appointment makes similar training for psychotherapists a legitimate proposal. Specifically within the context of psychodynamic therapy, I think including a lived-experience perspective would provide a space for therapists to reflect on their attitude and feelings about working with people with a diagnosis of psychosis.

**Cultural approaches which are inclusive of Māori**

Another implication for practice is for psychodynamic therapy to better adapt to an indigenous cultural position regarding psychosis. Woodard (2008) believes that by including historical, socio-political and environmental elements into the therapeutic paradigm "psychotherapy opens to the

possibility of clearly seeing indigenous psychological issues in their whole context rather than locating the dysfunction within the Indigenous person" (p.63).

Morice (2003) posits it is possible to align psychodynamic theories to specific cultural perspectives; in terms of Māori understanding, she relates the notion of psychosis as a defence to that of a "taniwha whose purpose is to protect the taonga of the embryonic self" (p.59). This is an example of how Kaupapa Māori theory can strengthen understanding and encourage curious enquiry into psychotic experience with clients, an approach that is not limited to Māori working with Māori, as is evident in the following example.

Dillon (2008), a Pakehā psychotherapist, describes his shock and discomfort when during a therapy session with a young Māori woman, he saw an image of an older Māori man in the room. He is candid in his belief that only clients have hallucinations, not therapists. After his cultural supervisor suggests seeing the man as a visitation rather than a hallucination he writes of his struggle to accommodate this view: "I wanted to make space within me for an indigenous model; I just did not want it to be this one; in part because it was so far removed from my psychotherapeutic models, and from my sense of spirituality" (p.95).

Over time Dillon was able to accept what he didn't know and he echoes in his writing key therapeutic factors that the writers in this research study have identified as helpful: that of acceptance, viewing each other as equals, and that, "an ounce of warmth and a willingness to relate is worth a pound of cleverness" (2008, p.101).

**Conclusion**

I began this research study process feeling slightly alarmed by how little material exists regarding first person perspectives of psychotherapy for psychosis. But I conclude feeling inspired. It has been a privilege to be granted research time to read such powerful lived experience accounts. I have learned a lot that I believe will benefit my own practice, and my hope is

that my findings can also be of use to others in the psychotherapeutic community.

I am also excited by the potential for progress: that people with experience of psychosis will occupy increasing roles in both the education and clinical sector, and that a psychodynamic therapy model can better incorporate culturally diverse approaches to psychosis.

As for the word "psychosis", I also look forward to when such a term no longer exists, and we can concentrate on peoples' individual experiences rather than a collective malady. I would like to acknowledge all of the people over the years who have shared their unusual experiences with me - in particular, Rhys, who first showed me how powerful one small step towards openness and acceptance could be.

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