THROUGH THE RABBIT HOLE:
WORKING WITH PSYCHOSIS AND CULTURE

by

JACQUELINE MAY BEAVERS

A clinical case study submitted
in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

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This clinical case study has been accepted for the faculty of

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In memory of Melissa McGeehan
&
Jacqueline Gustaves
“The shaman swims in the same water
the psychotic drowns in.”

--Joseph Campbell
ABSTRACT

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by

Jacqueline Beavers

This clinical case study describes an in-depth examination of working with an African American with schizoaffective disorder. Marcus, which is the pseudonym for the client in this clinical case study, is an African American male who was 28 years old when this project began. Marcus was diagnosed with schizoaffective disorder, with his primary symptoms being that of psychosis and depression.

Schizoaffective is a complex disorder that necessitated an exploration through multiple lenses. Marcus’ culture, both African American and Rastafarian, were important to understand, as historically African Americans have had a mistrust of mental health providers. Both are addressed through a socio-cultural perspective.

I began working with Marcus in 2007 and treatment ended in 2011. He presented as paranoid, delusional, having hallucinations, using alcohol and marijuana heavily, and dealing with extreme medical problems due to fighting. The over arching treatment goal was to develop Marcus’ various subjectivities so that he could explore other parts of himself besides the self that was mental ill. This was largely successful, as Marcus developed subjectivities other than mental illness, including his Rastafarian culture, his
working subjectivity, and his being a boyfriend in his first romantic relationship. While he was motivated to develop these subjectivities, he became more engaged in treatment and his substance use and symptoms decreased. We also grappled with the differences between us in gender and culture and the power struggles that ensued. As strongly as Marcus engaged in treatment, he also withdrew when tumult within his first relationship arose. The dynamics of our relationship fluctuated as well, as Marcus directed his anger on me and power struggles again resurfaced. By the end of treatment, Marcus was able to articulate his appreciation of our work together.

The study’s three main learnings that arose from this process included the importance of considering an individual’s environment, the need to find alternative treatment models to the medical model when working with the African American population, and the need to explore how the societal context determines severity of symptoms in clients with psychosis.

A reflection on my own story, my client’s story, stories of others, and myths in relationship to the concepts and principles of Marcus’ treatment are presented as well as interesting research avenues that could show how environment might lessen severity of symptoms through focusing on purpose and developing subjectivities in individuals with psychosis.
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CHAPTER 1

INTRODUCTION

Clinical Topic

Schizoaffective disorder is one the most interesting as well as complex disorders that mental health clinicians treat; the diagnosis includes symptoms from two separate diagnoses, which involve mood disturbances and psychosis. Although this disorder has been discussed for many years, the term has been written about less than depression, mania, and schizophrenia.¹

The literature related to schizoaffective disorder comes from research on depressive disorders and also on various psychotic disorders. The psychotic disorder that is most prevalent in the research is schizophrenia. Other diagnoses that share symptomology with schizophrenia and schizoaffective disorder are schizophreniform disorder, delusional disorder, and brief psychotic disorder.²

For the purpose of exploring schizoaffective disorder, an exploration of schizophrenic symptoms, specifically psychosis, has been necessary. Although the term schizoaffective disorder was coined in 1933, there is much more research on one of its main components, psychosis. Although, psychosis is a symptom found in other disorders such as substance-induced disorders, psychosis found in schizophrenia more closely resembles the psychosis found in schizoaffective disorder. The symptoms of psychosis occur when a person is not in touch with reality. Individuals experiencing psychosis are having an experience that is different from what is actually occurring in their external
environment. Psychosis shows itself through delusions and hallucinations. Those who experience psychosis also tend to be paranoid, disorganized, and lack social skills.

Because the symptoms of the depressive state found in schizoaffective disorder are most similar to those of major depressive disorder, literature on major depressive disorder was drawn from as well with a focus on mood instability and depressive states. Major depressive disorder causes low mood, flat affect, feelings of hopelessness, poor self-esteem, and lack of interest in activities. *Major depressive disorder* is usually more debilitating than any other depression diagnosis, causing functional difficulty, such as keeping jobs and maintaining relationships with others.

In addition to schizoaffective disorder, this clinical case study reviews the literature on the relation between substance use and mental illness. There is a high correlation between mental illness and substance abuse. While substance abuse leads to an increase in severity and duration of symptoms, it may also temporarily mask symptoms. The often persistent and overlapping relationship between substance abuse and mental illness is very important to address within treatment, as it can make it very difficult for people who suffer from both to manage symptoms.

This clinical case study also addresses African American culture in relation to mental illness. Amy Alexandria and Alvin F. Poussaint point out that in general, there is a lack of acceptance of mental illness within the African American community, along with a mistrust of providers, which has led to many African Americans who need treatment to not seek it. As a result, many African Americans find alternative ways to deal with symptoms of mental illness, such as suicide.
Through exploring all the symptoms of schizoaffective disorder and the correlation of substance use and cultural acceptance, it is hoped that this clinical case study will provide insight into the treatment of those who struggle with these issues as well as to provide a better understanding of the diagnosis of schizoaffective disorder, which is complicated in that it has several components. The research provided about this diagnosis could possibly inform others of this disorder and treatment options. In addition, the research of African Americans in relation to mental illness has been included with an aim to providing a better understanding of how to work with this population in the context of the mental health field.

Reviewing the various works of literature has been very helpful in this process in formulating learnings and being able to reflect upon these learnings. A holistic understanding of the topic, which led to better treatment of the client, was gained through reviewing information through multiple perspectives.

The Literature Review provides a context to begin to understand this case study of an African American client with schizoaffective disorder. The Literature Review’s biological perspective on schizoaffective disorder covers the history of studies regarding bipolar, depressive, and schizophrenic suffering. Sophia Vinogradov and Irvin D. Yalom note the importance of the work of Emil Kraepelin, who studied mood disorders, and Jonathon Leonhard, who researched the role of genetics and depression within affective disorders. An exploration around the chemical components of these disorders and medication options is also presented.

Edgar Nace’s research on mental illness and substance abuse shows a high correlation between the two issues, because, as Nace points out, the onset of alcohol and
drug dependency generally starts between 19 and 21 years of age, while depression and other affective disorders generally begin between 18 to 25 years of age.\textsuperscript{7}

The works of Aaron Beck and Neil Rector, and David Fowler illuminates the cognitive behavioral perspective that informed treatment with the subject of this clinical case study relative to his psychosis. The goals of cognitive behavioral therapy in the treatment of psychosis are to decrease external stressors, educate the client about psychosis and coping skills, and to reduce symptoms of depression.\textsuperscript{8} This section of the Literature Review focuses on the work of Beck, whose theory helps to address the negative symptoms of depression, as well as other cognitive therapy models.

Within the psychodynamic perspective, J. Allan Hobson and Jonathan A. Leonard discuss the works of Frieda Fromm-Reichman, who explores the idea of the "schizophrenic" mother. They also explore other works of various researchers who hold the perspective that family dynamics play a large role in psychotic diagnosis. These researchers include Gunter Ammons, who writes on disturbances of symbiotic relationships causing schizophrenia, and Manfred Bluer, whose research indicates that schizophrenia may be caused by a loss of parent at a young age.\textsuperscript{9}

The work of J.W. Perry is presented in detail as his work also informed the treatment in this case. Perry is valuable for his interest in exploring alternative ways to work with people who have schizophrenia besides medication, locked wards, and electroshock therapy. Perry emphasizes "the importance of looking not at the 'mental context' of psychosis but rather its relationship to the psychic life."\textsuperscript{10}

Looking at schizoaffective disorder through a socio-cultural perspective is perhaps the most powerful and most relevant way to understand the subject client of the
clinical case study, Marcus (pseudonym). Marcus was 28 years old when our work began, and race and race difference was a fundamental part of his world. Marcus is an African American male who identified himself as Rastafarian and struggled with poverty. Much of the work involved exploring his experiences as an African American male. It is essential to understand the reasons many African Americans are hesitant to seek out treatment. These reasons include past mistreatment by medical providers, medical experiments on African American individuals, subtle, white racism relative to their behaviors, inappropriate labels, misdiagnosis, and mistrust accrued over a lifetime of oppression towards white people who are overwhelmingly the providers for mental health services.\textsuperscript{11} Gaining a greater understanding of Rastafarian culture was important in treating Marcus, because the work helped guide Marcus towards his having a better understanding of his “Rastafarian self.” Many of the sessions focused on his identity in this area and how he experienced barriers in his ability to seek treatment because of this difference.

Another important aspect of Marcus’ treatment was the exploration of schizoaffective disorder through literature from the approach of imaginal psychology, which yielded rich material. This material includes Jef Dehing’s exploration of Carl Jung’s work on psychosis versus dream states and K. Evans, J. McGrath, and R. Milns’s exploration on Celsus’ work on different types of insanity, and various accounts of “madness” within the Greek and Roman culture. R.D. Laing is particularly important as he writes that the person struggling with psychosis is “on a profound, dangerous, mystical voyage whose purpose is to find new, deeper ways to communicate. The psychotic isn’t content with the ordinary ways of knowing that the ego offers, any more than the
religious mystic is.” This belief was pertinent to my subject-client, Marcus, in that many discussions took place regarding his psychosis being discussed as an ability versus a disability.

Other literature deeply relevant to the subject client of this clinical case study includes the extensive sources on African culture in relation to psychosis. In traditional African culture, mental illness and psychosis are not viewed as originating from chemical imbalance but rather from other issues, such as infestations of spirits. In Zimbabwe, spirits that cause psychosis are called *ngozi* and are thought to come from a situation within the family involving topics or items that are taboo.

Within other traditional cultures as well, different approaches to how cultures view and work with individuals who have mental illness have abounded. Paul Flesishman’s observations in India of individuals with mental illness led him to conclude that individuals suffer less because of the way their families and society treat them. He believes that these individuals suffer less because their families and society do not set them apart as being different, but rather “they have families. They are not subdivided into a separate class of society; they spend their days not in alien fluorescent-lit hospital rooms but sitting on charpoys in the shade of the earthen walls of their family home, surrounded by the hubbub of joint familial life yet tactfully excused from it.”

When I began to work with Marcus, I felt a strong sense of overwhelm in relation to all the issues he was experiencing. He was experiencing severe medical issues, potential loss of housing, family relationship problems, violence, substance abuse, psychosis, depression as well as many other challenges and hardships. Even without the diagnosis, Marcus was faced with many issues. It was difficult to determine whether he
would be experiencing these hardships if he were mentally stable. He was born into a community where these issues already prevailed but he might have been able to overcome them had he not had the diagnosis of schizoaffective disorder.

Marcus’ severe depression and psychosis really limited his ability to work, preserve his housing, relationships, and maintain his substance abuse. After treating Marcus for a month, I began to believe that two factors underlay the limitations I observed. One included the actual symptoms that he was experiencing, such as hearing voices, his delusional thought process, paranoia, isolation, and low self-esteem. These symptoms made it very difficult for him to explore the parts of himself that were not related to his psychiatric disorder. This leads to the second limiting factor regarding Marcus’ work, such as housing. Marcus’ only real life activity for the past decade had been related to dealing with his mental health issues. He seemed therefore to have only developed an identity that reflected his psychiatric issues. Every aspect that I initially observed about him seemed to be tainted with his feelings or thoughts about his mental illness. It seemed that prior to his work in the psychotherapy with me, he had never had an opportunity to focus on exploring who he was, besides being a mental health patient.

It truly saddened me to see a young man so limited by the oppression of his diagnosis and how this oppression had played out within the psychiatric and welfare institutions in which he had participated. Yet his youth also gave me hope that he could start to develop his potential with a little encouragement.

I was drawn to asking Marcus to be the subject of my clinical case study because he really did develop and transform during our work together. When we initially started working together, he presented without much affect, much verbal coherence, or much
hope. My work with Marcus included training in methodology that I learned from Meridian University, called *Imaginal Process*, which is Meridian’s approach to transformative learning. This work involved exploring Aftab Omer’s concept of *imaginal structures*, “assembles of sensory, affective, & cognitive aspects of experience constellated into images. They mediate and constitute experience.”  

I worked with Marcus on acknowledging his structures that have limited his ability to see other parts of himself. Through this process, we were able to identify his *subjectivities*, which can be described as his different “selves” or parts of himself. Through looking at these subjectivities within the context of imaginal process, Marcus was able to address the repression of his subjectivities and to participate in the idea that we have many “selves” which is defined as *multiplicity* within imaginal process.

Clinicians spend so much time looking for issues to fix, but I wanted to explore an alternative path with Marcus, believing that he would benefit from an equal amount of time spent assisting in the exploration of his subjectivities. My work with Marcus is testimony that this approach can potentially be more healing than any other approach.

Another reason I was drawn to using Marcus as the subject of my clinical case study was because the work demonstrates a way of working with differences in culture between therapist and client. In our work together, we discussed the differences between the two of us regarding our race and gender. He was open to discussing how this created a dynamic in our therapeutic relationship. This dynamic of race, gender, sexual orientation, and age differences in my work with clients had surfaced frequently throughout my career. Although dynamics around age differences lessen as I get older (I
started counseling work when I was 22 years old), the issues around the other factors remain.

Since I began working as a therapist, I have become much more comfortable working with these dynamics. In the beginning of my career, I wanted to draw on similarities between my client and myself. This allowed me to demonstrate empathy more easily and create a level of comfort for both my client and myself. However, I now realize that not challenging my clients created a situation in which they would not grow. I trusted that Marcus would be able to handle this topic and that doing work around it would be beneficial to his treatment. Not only was it beneficial to his treatment, these discussions were beneficial to my growth as well. Marcus taught me about his culture as well as assisted me in building confidence in addressing our differences. The fact that culture and cultural differences between therapist and client were an active part of the conversation in Marcus’ therapy contributed to my strong desire to address this topic in this clinical case study.

**Personal Exploration of the Subject/Topic Choice**

I felt connected to having Marcus as my subject client due to the many issues as well as milestones that he experienced. I related personally to some of these experiences. The work I did with Marcus allowed me to examine some of the issues that I had been dealing with in my personal life as well in my professional life.

I found myself relating to Marcus’ depression. I too had suffered with depression since childhood. For the most part, I was able to mask it and I have attributed much of it to my family dynamics. Looking back, I realize that children are not supposed to feel a
lot of what I felt. I realize that I internalized my suffering and others’ suffering to the
point of not allowing myself to enjoy life. My depression got progressively worse as I
entered high school. I found myself getting “sick” and refusing to go to school. I used
physical sickness as a reason for not going to school because I was unable to understand
the psychological issues that I was struggling with at that time. I found myself sleeping a
lot, isolating, thinking about suicide, and I was very weepy. I did continue to maintain
friendships and interact socially, but this created added pressure to maintain a
presentation that “everything is fine.”

During our work together, Marcus also worked to maintain the presentation of
“everything is fine.” I believe due to his gender, his African American heritage, and his
being a part of the Rastafarian culture created even more of a dynamic for him to present
as strong and without “flaws.” I related to his desire to not be vulnerable. I respected this
desire, but I also was able to see that it was tearing him apart.

I also felt a connection with Marcus regarding his delusional thoughts and
hallucinations. As a small child, I remember seeing things that others said that they did
not see. At night I would lay frightened in bed as images of tanks, snakes, jungles, and
guns appeared in black smoky images before my eyes. Every few nights I would see a
white ball of translucent, fog-like substance move around my ceiling. It had a long tail
that appeared to dissipate into the air. Every morning, I would wake up and look outside
my window into my neighbor’s back yard. Every few days, a glowing statue would
appear. It was a statue of an animal with horns. It stood on its legs and looked like a
person. It had long necklaces of flowers and a crown of flowers on his head. I enjoyed
seeing this structure while the other structures terrified me. No one believed me and I
realized at a young age that I needed to keep these experiences to myself. These experiences stopped when I was around the age of five. I still do not know what caused these hallucinations or visions. I often wonder, was it my imagination? Was it real? Was I mentally ill? All I know is that this was my reality and I did not question it. I was also aware that this was not other people’s reality.

In my later teen years, I began to use illegal drugs, such as LSD, mushrooms, cocaine, ecstasy, ketamine, and methamphetamines. At first, my experiences with these substances took me to places where my depression did not exist. I heard, saw, and experienced a world that did not exist in normal reality. I enjoyed these “trips” and felt a part of something bigger than myself. As time went by, my experiences became less enlightening and more frightening. Also, the side effects of my use were playing out even when I was not using substances. I thought I could hear what people where thinking about me, and it was never positive. I began to hear faint voices, which exacerbated my paranoia. I was convinced people hated me and were trying to take advantage of me. I became distrustful. I did not always feel this way but it definitely occurred more and more every time I used substances. I remember saying to some of my friends, partly as an attempt to normalize my experience, partly to use humor to avoid looking at the severity of the situation, “I am going to use these experiences later to relate to those I work with in my career.” I suppose I said this also in an attempt to justify my actions. My friends found this amusing and still remind me of this statement years later.

I do believe that these experiences, good and bad, allowed me to empathize with Marcus when he experienced psychosis. They gave me some insight into why Marcus covered his windows with sheets, was mistrustful, and seemed to be in his head most
times. These experiences also helped me have compassion for him around his suffering and feeling of aloneness he most likely experienced when in his psychotic states.

Lastly, I was drawn to exploring the subtle dynamics involving race and differences between therapist and client. The dynamic between African Americans and Caucasians especially interested me. I was able to explore this dynamic mostly through exploring the culture of African Americans in regards to treatment of mental health issues.

I grew up outside of Washington, D.C. where racial tension ran and continues to run high between African Americans and Whites. I went to private school as most white kids did in this area. There were African American children in our neighborhood that I played with until I was around seven or eight years old. At this age, I found that race does start to matter, and racial differences seemed to matter even more. Children I had known from infancy would play in their own yards, while I played in my yard next door, without a single interaction between us except maybe a name call here or there. My older sisters who attended public school came home with black eyes and torn clothes. They told me African American kids did this to them. As I became aware of racial tension and acts of racism-related violence, I became to believe the erroneous racist messages that I heard about African Americans and generally come to feel fearful of them. Over the years, African American families moved out as the neighborhood was gentrified.

My interactions with the African American culture continued to be limited by my attending a private school, which was almost exclusively populated by middle to upper-middle class white students, while living in a similarly populated neighborhood. However, the summer before my senior year, I had to take a summer school class at the
local public school. This experience proved to be terrorizing for me: I was thrown against lockers, boys would press their bodies against mine; I was called a “snotty whore,” my clothes and jewelry were torn by girls, and I was made to eat at a table by myself at lunch. This was a startling experience.

At the time, I did not completely understand why this happened to what was a minority of white kids at the school. I witnessed similar incidents occur against other white students, especially girls. In retrospect, I could understand how it could be perceived that we, the white kids, were invading the turf of students of color. Somehow our presence seemed to bring to the surface the differences that existed between us. For example, we would be leaving this place of mediocre education with old textbooks and teachers who did not want to be there while they would not. We had a choice and they did not. What I did know was that I felt bad. I felt that it was my fault in some way, which I did not really understand at the time.

This experience led to a 15-year journey of working with my anger, guilt, sadness, and hurt pride around this dynamic. I have worked to hold compassion for myself and for those from the African American culture. Living in San Francisco, I still feel the tension but with less intensity. This has allowed me to work on these issues without so much fear. I have really engaged in this area through classes, trainings, reading, and talking with others of my race and other races. This has helped me have more peace. This has also helped me understand the importance of not ignoring the “white elephant” in the room but addressing it in an authentic and real way.

I respected and understood Marcus’ mistrust of white people. Being around the same age, I understood on some level how we were raised to be one race, the human race,
but still expected to be separate and oppositional towards one another. Our parents were alive during segregation and of course their feelings about this would be a part of our generation. Being able to work with Marcus around these racial wounds really gave me insight into myself as a clinician and a person.

Although I would never say that Marcus and I have experienced similar lives, I would say that his life and our work together has helped me in many ways to develop and transform. The similarities in our personal experiences, while minimal, have provided a context in which to do work within.

**Framework of the Treatment**

From April 2007 until August 2011, I was an employee of Westside Integrative Services, a community mental health clinic in San Francisco, which is the setting in which I worked with Marcus. My title was clinical case manager, which is a hybrid of a therapist and a case manager. There were six clinical case managers on the outpatient team with approximately 50 employees in the whole building, which included multiple programs. The case managers in the outpatient program had caseloads of 40 to 50 clients. They met with their clients from once a week to once a month. Due to my working with more difficult cases, I had a caseload of approximately 25 clients, who I saw approximately once a week.

I worked with Marcus in a case management, group therapy, and individual therapy context. I worked with him in various settings: at the clinic, at his home, over the phone, and accompanied him on various appointments in the community. Marcus also
saw a psychiatrist every six weeks, and he had attended groups run by other clinicians in the past.

Due to the nature of my position, which allowed for significant outreach and more frequent sessions, I was asked to take on Marcus’ case; he had recently been in a fight that had caused severe eye damage and a broken foot. In addition, his symptoms of psychosis and substance abuse had also increased along with more erratic behaviors. It was felt that he needed more care than his case manager could provide.

I met with Marcus for approximately 300 meetings, which included one-on-one sessions, phone conversations of 15 minutes or longer and groups over the four-year period between August 21, 2007 and the end of August of 2011. The frequency of our sessions varied. When Marcus was in crisis, I saw him more regularly. For the first two years, I met with Marcus at least weekly for individual sessions and weekly in a harm reduction group that I ran. During the end of the second year, Marcus started working more regularly in his employment, which subsequently led to his disengaging and somewhat resulted in lessening our contact. Later in his treatment, Marcus began to disengage from treatment due to an increase in substance use and an increase of symptoms.

As our rapport increased and concrete needs were addressed, we focused less on case management and more on therapy. A good portion of my work with Marcus was therapy from a cognitive-behavioral approach due to agency requirements. Along with cognitive-behavioral therapy, I incorporated theory and methods from Imaginal Process (Meridian’s approach to transformative learning), humanistic, narrative, and client-
centered therapies. Although we addressed many issues in our work together, the main focus was on symptoms management, substance use, and self-acceptance.

**Confidentiality and Ethical Concerns**

Throughout this clinical case study, a pseudonym for my client has been used. This is the protocol for clinical case studies at Meridian, in order to fully protect the privacy of subject clients that are written about in these studies. As such, I explained thoroughly to my client that his identity would be protected. After a year of working together, I asked Marcus, if he would consider allowing me to use him as the subject client for my clinical case study. He agreed without much enthusiasm and did not have many questions. I made sure to ask him when his symptoms were minimal and he presented in a stable manner. I did not feel that it would be clinically appropriate or ethical to ask him when he was in a depressed state or psychotic since I wanted him to be able to make the decision to participate when he could think rationally. I also thought that asking him when he was in a psychotic state would increase his paranoia.

I told Marcus that the main reason I wanted to use his case was that I was very impressed with the work he had done. He smiled at this and seemed pleased by the reason. Later on in our work, I asked Marcus to sign the *Informed Consent Form*, which gave his permission to allow me to use him as the subject client and is a requirement for writing the clinical case study. He signed the form, but said, “What do I get out of this. I should get something.” I told him that he did not have to sign the consent, that participating in the project was voluntary, but I did not comment on what, if anything, he
would “get out of this.” Marcus seemed to think about this for a minute, and then he signed the consent.

I received individual and group supervision once a week from Alysia Linsenmeyer, LCSW. Like myself, Alysia Linsenmeyer did not work from a single orientation, which allowed for an exploration of multiple theories and treatment approaches. I had received supervision from her since the beginning of Marcus’ treatment. Besides our set supervision times, I consulted with her on a regular basis. She was very helpful, especially in the latter part of my work with Marcus when she helped me process Marcus’ disengagement from treatment. Alysia had worked therapeutically at various points with Marcus, which allowed her to have more insight into his case. The other clinicians who participated in group supervision also had worked with Marcus in a group context or individual context. This allowed for a more collaborative approach to working with this case.

I attribute the fact that I did not have many ethical issues in working with Marcus primarily to the flexible nature of my position. Our meetings were not limited to meeting within the walls of the agency building. The way I served Marcus was not limited to discussing symptoms, but there were times when I questioned what was appropriate and not appropriate when working with Marcus. For example, working with Marcus around his substance abuse with a harm reduction approach sometimes raised ethical questions, which involved issues around supporting his substance use. Working from a harm reduction approach involves working on helping clients to reduce substance use without an insistence on immediate sobriety. Also holding and managing Marcus’ money brought up questions around legal rights. I struggled with how much and how often I could use
his money as an incentive to meet his treatment goals. Legally, Marcus could take all of his money besides his money for housing, but it was a general clinic policy to hold money for budgeting purposes and incentives to meet goals. Throughout our work together, I struggled with what was best for Marcus versus wanting to support his legal rights. I found it difficult to do both, and he showed little insight into my dilemma.

Client History and Life Circumstances During Therapy

Marcus was born in San Francisco in 1979 to a married couple. His father had two sons from a previous relationship. His mother and father separated when he was three years old. When Marcus was 12, his mother had a daughter with her current partner.

Marcus dropped out of high school when he was 14 years old. He moved to Florida to live with his father, and he began using marijuana and alcohol heavily during this time. He also began to experience symptoms of psychosis and depression in his late teen years. After a period of time of being homeless in Florida, Marcus returned to San Francisco.

When Marcus was 19, he was psychiatrically hospitalized for attempted suicide by ingesting rubbing alcohol. He reported that the suicide attempt was due to psychotic and depressive symptoms. He said he experienced hallucinations and paranoia. This was one of the first times he had experienced these symptoms and he was frightened.

Marcus was hospitalized multiple times between age 20 and 22. One of the hospitalizations occurred after he tried to hang himself. I questioned Marcus about this incident and he was very guarded and would not provide any details. I was not able to gather more information because the clinician he worked with at that time had left the
agency years before. As well as hospitalizations, Marcus also spent time in mental health residential programs and crisis stabilization programs before he began treatment at Westside Outpatient Clinic.

Throughout his 20s, Marcus used alcohol and marijuana heavily. He attended various groups for mental health issues and individual sessions with various case managers at the clinic. He did not work more than two weeks consecutively during this period of time due to his inability to show up for work. He also moved to a Conard Support Services hotel, a low-income apartment building that provided assistance to its residents regarding obtaining food, medical referrals, social skills building, and therapy.

Just before I began to work with Marcus, several events occurred. He engaged in several fights, which led to severe eye damage and a broken foot. He also flooded his studio at the support hotel, which occurred when he was intoxicated and became unconscious. The water leaked onto the floor beneath his studio. Marcus was given an eviction warning and required to pay for damages. Marcus’ psychotic symptoms also increased. The delusions he experienced led him to believe people were watching him, and his auditory hallucinations increased.

Our work together began at this point in Marcus’ life. Marcus tended to his physical issues while I set up a payment plan for the water damage. He began to heal physically and his symptoms of psychosis decreased. Shortly after we began working together, Marcus’ father passed away. At this point, he began to come to the clinic more often. After a period of discussing his grief around his father’s death, he showed motivation to make some positive changes in his life. He attended a vocational program and started a job as a janitor. His substance use decreased along with his symptoms of
psychosis and depression. Marcus attended Harm Reduction group, which was ran by myself and other functions held at the clinic. Marcus became involved in a romantic relationship with an older woman, which ended a few months later. During our time working together, Marcus struggled with budgeting his money, which led to much conflict between us. He was over paid by social security and eventually his social security checks were lessened to make up for the difference. Marcus began to use substances more, missed work, and disengaged from the clinic and myself.

**Progression of Treatment**

I began working with Marcus in August of 2007 and our work ended in August 2011 when I resigned from Westside Community Services, the agency through which I was working with Marcus. This clinical case study mainly focuses on my work with him through 2009 (although I continued to work with him almost two years beyond that) for two reasons: first, the majority of the major issues and dynamics in the work with Marcus and discussed in this clinical case study took place during the first half of treatment. Second, focusing as closely on the second half of the treatment as I did on the first would have exceeded the scope of this clinical case study. I have included information on the second half of the treatment, which shows a continuation of various issues and client-therapist dynamics.

During the first six months of Marcus’ treatment, we addressed Marcus’ fighting and subsequent medical issues and how his fighting was related to his heavy use of alcohol and marijuana. There were also many interactions that involved my managing his money and the difficult feelings that arose because he could not manage his own money.
We also worked on Marcus feelings and experience towards women and white people. The most important breakthrough of our treatment that occurred during these six months was that Marcus opened up about his hallucinations and delusions. At the end of these six months, Marcus’ father passed away.

During the second six months, from early March 2008 to late August 2008, a decision was made to allow Marcus to receive all his money at the beginning of the month; however, he continued to have problems budgeting. Marcus participated in a weekly harm reduction group to address substance abuse issues. Marcus’ brother was released from prison and moved in with him. He started to work on family relationship issues and setting boundaries. During this time, Marcus also had two small fires in his apartment due to his leaving the stove burner on. Marcus was evicted and moved to a small, single residence occupancy, which is low-income housing. Although there was a lot of drug activity and substance use in his new environment, Marcus’ use decreased. Marcus also began a vocational program.

During the third six-month period from September 2008 to February 2009, Marcus continued to maintain somewhat good mental health. He graduated from the vocational program and started a part-time janitorial position. Marcus also was diagnosed with gout and tended to his medical issues. Marcus began dating a white woman who was 20 years older than him. We began deep work around the stigma of having a disorder that starts with the prefix, “schizo.”

During the fourth six-month period from March 2009 to September 2009, Marcus began to disengage from treatment. He was broken-hearted that his relationship did not work. He stopped showing up to appointments for groups, nurse practitioners, and
myself. When meeting with me, Marcus reported that his only focus was looking for work at this time.

From September 2009 to December 2009, Marcus found work one day a week as a security guard and continued working as a janitor through the vocational program. He disengaged further from treatment, which now included him not picking up his medication. He became increasingly more closed off and withdrawn during our infrequent sessions and was not open to discussing the many topics we had addressed previously.

The following portion of this treatment progression describes what occurred in the years of 2010 and 2011 but as mentioned above, is presented in much less detail than the prior three year’s work (2007, 2008, and 2009).

During 2010, Marcus continued to disengage from the clinic, and he became more hostile and angry toward me. He met with my supervisor and myself due to his aggressive behavior. There was a decrease in his social security amount due to his vocational program not sending his paystubs to the Social Security office. His payments were supposed to be modified based on his work, but this did not happen, and his payments were subsequently decreased for 2010. His work hours decreased which led to a huge cut in his monthly income. Although it was not my responsibility, Marcus was convinced that this was my fault and he let me know it every time we met over a period of months. Marcus’ substance use increased and he did not take his medication as prescribed.

During 2011, it was decided that Marcus would receive money management elsewhere and that he would be transferred to a different case manager as soon as he was
linked to Conard Payee Services. Marcus agreed that this would be the best solution. A month later, Marcus admitted that his life was not manageable. He began to engage more with the clinic. He decided that he wanted to continue working with me. I informed him that I was pregnant and we would discuss this when I returned from maternity leave. Marcus continued to become more open regarding his current issues of substance abuse, increase of symptoms, and issues around money. I decided that I was not going to return to the clinic after having the baby and shared this with Marcus during one of our last sessions. In those last few sessions, we were able to review the many ups and downs of our relationship as well as the importance we both played in each other’s lives.

**Learnings**

Although I learned much from working with Marcus and my research on the topic for this clinical case study, that of schizoaffective disorder, three learnings especially stand out. My first learning involved the importance of looking at an individual’s entire environment in order to fully understand a person’s suffering. Many times, people do not express fully how they are feeling or leave out pertinent information. This especially pertains to those that suffer from psychosis due to their mistrust and paranoia of others.

My second learning led to a better understanding of the issues that African American clients commonly experience relative to mental health treatment and the mental health system as a whole. The mistrust around treatment stems greatly from negative past experiences with the mental health and medical fields. This learning also allowed me to address my personal interactions with this community and my journey to better understand in order to have compassion.
The third learning involved a greater comprehension of how psychotic symptoms manifest differently in different societies and cultures. I learned that other cultures work differently with their mentally ill and view the mentally ill sometimes as spiritual guides. I believe these views allow the individual to thrive and perhaps not suffer as much as those in our culture do. Through evaluating my work in the context of these learnings, I found myself more able to participate in Marcus’ treatment and my own personal development.

**Personal and Professional Challenges**

Although I began my work on this project in 2009, I continued to work with Marcus until August 2011. Working on this project while simultaneously providing treatment to Marcus proved difficult in many ways. It was a struggle to not let my interactions with Marcus at the time color my interpretation of the first part of his treatment.

In the first half of our work together, we built a strong rapport and there was minimal conflict between us. Although there were moments when we were both frustrated with each other, for the most part we genuinely enjoyed each other’s company. Marcus relied on me and this reliance gave me purpose.

During the second half of the treatment, Marcus disengaged from treatment and eventually became very hostile towards me. When I addressed this, he would not engage with me but instead pushed me away further. Marcus became verbally abusive towards me and at times aggressive to the point that a third party had to be brought into our sessions.
At the beginning of Marcus’ disengagement from myself and from treatment, I struggled with a sense of feeling useless. I compared this sensation to how parents must feel when their children begin to individuate and then leave the “nest.” He was doing very well at this time. He had completed his vocational program, he was working, he was not using substances heavily, and his symptoms seemed to be manageable. He did not need me as much and my praise seemed to mean less to him. I was somewhat frustrated by this and had to do a lot of work around my own sense of not feeling needed. This was not the first time this issue had come up for me.

Ironically, Marcus eventually began to decompensate and began using substances more heavily. His work was reduced and his income was decreased due to the complication with his social security for which I was blamed. I actually began to see him more often but with this came hostility and aggression. I found myself secretly comforted by the fact that he needed me again, even if it was to engage conflict. Once again, I had to explore my extreme need to be needed. I realized that this dynamic would surface frequently throughout my career and I started to look more closely at it. I began to question whether I would be fulfilled when my clients started to get better and there was no use for me. The goal of my work is to make people “better” but I began to wonder whether, meeting this goal would cause me to feel worse.

I also felt challenged around working with Marcus’ mother and the lack of positive support she provided her son. She rarely contacted me but when she did it was because she felt I was to blame for something. For example, she was very upset that I would not let Marcus purchase a refrigerator, which was causing his food to go bad. This put me in an awkward situation because I did not want to tell her that I had given Marcus a
check the month before to buy a refrigerator. I wanted to keep Marcus’ trust so I did not tell her this. I did meet with Marcus who admitted to buying other things with the check. I encouraged him to tell his mother the truth, which I do not believe he did. This is just one example of situations I was put in regarding his mother feeling that I was not doing my job around money management and providing safety for her son. As well as his mother, there were other times I was presented to his other providers as being a “bad” case manager. I found this very challenging due to the fact that I felt I was doing everything I could to support him.
CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

This chapter begins with the literature on schizoaffective disorder, which covers both symptoms of schizophrenia as well as symptoms of mood disorders, because these symptoms are congruent with the phenomenological experience of this disorder, in which the individual experiences both sets of symptoms. Schizophrenic symptoms include hallucinations, delusions, disorganized behavior, and flattened affect. Mood disorders include states of depression and mania, which is an elevated state. There is much literature on schizoaffective disorder from the biological perspective, but the literature on schizoaffective disorder from psychological and sociocultural perspectives is limited. However, there is a great deal of research from the cognitive-behavioral, sociocultural, and psychodynamic perspectives on schizophrenia and mood disorders. It should be noted as well that from the imaginal perspective, there is limited literature on schizoaffective disorder as well as the two components that make up the disorder.

As a result, a substantial portion of this review is devoted to an exploration of the two components that comprise schizoaffective disorder. In addition, the review’s main focus is on schizoaffective disorder, depressed type, as relevant to the case. Some information on mania is provided, but there is more information on depression in relation to psychosis.
Many perspectives are fundamental to gaining a greater understanding of schizoaffective disorder; therefore, schizoaffective disorder is viewed through five separate perspectives. These perspectives are biological, cognitive/behavioral, psychodynamic, sociocultural, and imaginal. This review also covers the disorder within other socio-cultural contexts; including where mental illness fits into society, the African American culture, and its relation to mysticism.

The biological perspective section is divided in two sections. The first section covers literature on schizoaffective disorder and schizophrenia, while the second reviews mood disorders from the above-mentioned perspectives. The section begins with the different theoretical perspectives about the chemicals implicated in the psychotic component of schizoaffective disorder. Although there is agreement that the primary chemical is dopamine, viewpoints about how it is related to mental illness have varied over the years. The next portion of this section reviews various types of treatment for symptoms of schizoaffective disorder and schizophrenia, including medication, its various side effects, lobotomy, and electroshock therapy. The following portion of the review discusses genetic associations and ideas of how physical environment may cause psychotic disorders.

The second section, on mood disorders, reviews the definition and types of mood disorders, genetic correlations between families and mood disorders, and an exploration of medication and side effects. This section also addresses substance abuse and dependency in correlation with mental illnesses. The review then covers the cognitive-behavioral perspective, addressing psychosis first, and then mood disorders, from this perspective. Many cognitive experiences that occur within psychosis are reviewed,
including delusions and hallucinations. Cognitive-behavioral therapy (CBT) is also introduced as a treatment model to work with psychosis.

The section on mood disorders focuses primarily on depressive symptoms. In addition, as Cognitive Behavioral Therapy (CBT) has been effective in treating depression, literature on treatment from this perspective is included. The literature on social constructionism, an alternative, lesser known, cognitive lens is also presented. The last part of this section explores the contribution of Eastern philosophy to cognitive-behavioral approaches.

The third perspective reviewed is psychodynamic. This section primarily focuses on different theorists and their beliefs about the causes of schizoaffective disorder. The theories of Fromm-Reichmann, who conceptualized the schizophrenogenic mother, are introduced, followed by a review of the ideas of Perry, Harry Stack Sullivan, and Laing who looked at the unconscious, the ego, and alternative ways to treat patients besides medications and locked psychiatric wards.

The next section addresses the socio-cultural perspective of schizoaffective disorder. The primary focus is on mental illness in the context of the African American culture. This includes an exploration of barriers to treatment. Various race specific disorders have been conceptualized over many years. A few of these are mentioned, followed by a substantial review of the Rastafarian culture. Due to the fact that the literature on mental illness is limited from the perspective of this culture, this section provides more of a perspective on the culture as a whole and less on factors related to mental illness. The final portion of this perspective reviews a culture in India and in
Africa, which offers a varying paradigm than the West when it comes to approaching mental illness.

The final section of the review focuses on schizoaffective disorder through the approach of imaginal psychology. Dehing explores Jung’s exploration of archetypes in the first section. The following section explores mental illness from the perspective of ancient cultures, such as the myths regarding psychosis, which can be found in Roman and Greek cultures. The link between religious experiences and psychotic experiences is then presented.

**Biological Perspective on Schizoaffective Disorder**

The following section begins with a historic overview of schizoaffective disorder as a diagnostic category. It includes a brief biological explanation of the causes of schizoaffective disorder and addresses treatment options and genetic correlations. The section then focuses on the main elements of a schizoaffective diagnosis, symptoms of psychosis and mood or affective disorders, specifically depression. This review also provides a general historical overview of mood disorders and schizophrenia. This includes various treatment options, such as medication and electroshock therapy. Thirdly, an important area of interest is the high rate of correlation of these disorders in family; therefore, this literature is reviewed. The review of the literature also touches on the deficit of using a medical model alone when treating these disorders.

Vinogradov and Yalom describe how in the 1893, Emil Kraeplin discovered a disorder called dementia praecox, which shared symptoms with what would later become known as schizophrenia. Unlike dementia found in the elderly, the disorder had similar
features but occurred early in life. He believed that this disorder is caused by a brain pathology.\textsuperscript{1} Vinogradov and Yalom also write that in the 1908, Eugen Bleuler coined the term \textit{schizophrenia}. Both Bleuler and Kraeplin believed that schizophrenia is caused by an element of toxicity.\textsuperscript{2}

In 1933, Jacob Kasanin introduced schizoaffective disorder, which he described as “a psychosis with prominent schizophrenic \textit{and} affective symptoms; since then, the term’s use has been equally ‘schizophrenic’ and ‘affective’.”\textsuperscript{3} Jerrold Maxmen and Nicholas Ward note that researchers and clinicians continue to disagree over whether schizoaffective disorder is a genuine disorder. Some maintain that it does not exist in its own right, but is simply a provisional diagnosis that should be used until schizophrenia or an affective disorder is diagnosed.\textsuperscript{4} To be diagnosed with schizoaffective disorder, a person must have an extended period of illness without interruption which includes a major depressive episode, a manic episode, or a mixed episode which occur with symptoms that meet criterion A for schizophrenia (e.g., delusions, hallucinations, disorganized speech, disorganized behavior, negative symptoms).\textsuperscript{5} Thus there is a strong overlap of symptoms of mood disorders and the psychotic symptoms of schizophrenia.

To better understand the origin and nature of the psychotic symptomology if schizophrenia, scientists in the 1960s began to do research with lysergic acid diethylamide (LSD). According to Perry, “What the psychedelic trip amounts to, after all, is an artificially induced state which leads the individual directly into the same dimension of inner experience as the psychotic episode we are studying.”\textsuperscript{6} Vinogradov and Yalom explain that because LSD produces significant perceptual changes such as hallucinations and distortions of reality, some researchers postulate that certain brain
abnormalities must be responsible for schizophrenia; these abnormalities create substances in the brain, which are not too dissimilar from LSD. Although this hypothesis, known as the transmethylation hypothesis, had logical appeal at the time, research has failed to find direct evidence for it.\(^7\)

Researchers in the 1970s began to turn their attention to dopamine as the cause of schizophrenia, although there was some debate over dopamine’s role in schizophrenia in the decades that followed.\(^8\) Dopamine is the primary substance that activates the reward system in the brain. Dopamine is a neurotransmitter that is activated when cocaine and other stimulants are used. Cocaine and antipsychotics both block dopamine receptors. Amphetamines increase the concentrations of dopamine into the system, which can lead to a psychotic episode.\(^9\) The research of substances such as cocaine and amphetamines has been very helpful in understanding how the brain processes dopamine. Antipsychotic medications are effective in suppressing dopamine, which in turn reduces psychotic symptoms. However, they have side effects that decrease an individual’s spontaneity, interest in the world and creative pursuits.\(^10\) P.R. Breggin argues that while antipsychotic medicines suppress dopamine activity, they suppress other neurochemical activity as well, essentially performing a “chemical lobotomy” on the brain.\(^11\)

Aside from the above side effects, there are many others that come with taking antipsychotic medications. One of the more prevalent is tardive dyskinesia, which involves involuntary movements of the tongue, lips, face, hands and feet.\(^12\) There is about a 30 percent chance that an individual on antipsychotic medication will have tardive dyskinesia.\(^13\) Research reports that of “people over 45 years, 26 percent develop
tardive dyskinesia after just 1 year on drugs and sixty percent after three years. Twenty-three percent develop severe tardive dyskinesia within three years.”

Among brain abnormalities that were found in those with schizophrenia were larger than usual ventricles, or fluid-filled spaces, in the brain. Technological advancements, such as computerized tomography (CT) scans, allowed researchers in the 1970s to discover that people with schizophrenia had larger ventricles than those without schizophrenia.

In addition, Hobson and Leonard note that the findings of twin and sibling studies pointed to the idea that a specific gene or a combination of genes may cause schizophrenia; however this gene or genes have yet to be discovered. Although a gene has not been identified, studies show that there is a strong genetic component in schizophrenia. The likelihood of twins having schizophrenia is greater than those of dissimilar families. Twin studies conducted by Pekka Tienari et al. show that there is a 50 percent greater likelihood that twins will have schizophrenia and other psychotic disorders compared to those in the general population. Although a strong genetic component is evident, environment also plays a large part in manifestations of the disorder. In studies involving adopted twins, there is evidence that 86 percent of children who live in a good environment with protective factors are not diagnosed with the disorder. Research also shows that prenatal stress can make it more likely that a mother will give birth to a child who is more susceptible to schizophrenia as well as other mental illness, than children who are born to mothers without prenatal stress.

As these findings suggest, there is strong support for schizophrenia being caused by physical environmental factors, which would explain the high correlation between
siblings having schizophrenia due to being raised in similar environments. Timothy Crow’s *contagion hypothesis* holds that viral infections or other environmental toxins could be factors implicated in the cause of schizophrenia. Although this is a little known theory, some researchers believe it is one that should be given greater notice. Richard P. Bentall, Loren R. Mosher, and John Reed write “that schizophrenia should be due to an infectious agent is not widely entertained, but the paucity of alternative theories requires that it be considered.”  

18 At this time, much of the research that is taking place within the medical model involves medication trials, which review the benefits and negatives of use of medication. There is currently little attention on external factors that might cause schizophrenia.

In order to gain a better understanding of the biological perspectives on schizoaffective disorder, this section explores mood disorders, with a primary focus on depressive symptomology, which are integral to a diagnosis of schizoaffective disorder. Mood disorders are a broad category of diagnosis. Under the mood disorder umbrella, there are *unipolar* and *bipolar* disorders. Frederick K. Goodwin and Kay Redfield Jamison explain, “Mood disorder is the overall category for entities whose predominant symptom is usually a pathological mood: dysphoria, euphoria, or both. In DSM-IV, mood disorders that consist solely of ‘low’ are called ‘major depression’ and its milder version, ‘dysthymic disorder’; those that combine ‘highs’ and ‘lows’ are called ‘bipolar disorder’ and its milder form ‘cyclothymic disorder’.”

19 It should be noted that one of the more problematic mood disorder diagnoses is the cyclical variety, which include bipolar disorder and cyclothymic disorder, which contain both a depressive and manic/hypomanic state. Goodwin and Jamison note that
there is much debate over the extent to which psychosis should be considered a component of a cyclical mood disorder. \(^{20}\) They note the difficulty early researchers had in demarcating the two major psychotic disorders at the time. They state, “It was left to Kraepelin to segregate the two major psychotic illnesses—manic-depressive insanity and dementia praecox—from one another and clearly draw the perimeter around manic-depressive illness.” \(^{21}\) In 1899, Kraepelin researched and worked with manic depression, the former name for bipolar disorder, and struggled to make a distinction between manic depressive illness, which included circular psychoses and simple manias, and melancholia, which was an early category for depression. Circular psychosis was a broad category that included the two current diagnoses of bipolar and schizoaffective disorders. Goodwin and Jamison write that Kraepelin tried to make a distinction between circular psychosis and melancholia, “which were really separate illnesses, but he was still reluctant to take a definite stance.” \(^{22}\) After many years, Kraepelin began to examine cyclical disorder or mood disorders without the psychotic feature. However, the wide category of manic-depressive disorder was also problematic. Hobson and Leonard observe, “Within the broad category of manic-depressive illness, some patients had histories of both depression and mania, whereas others had depression only.” \(^{23}\)

Like schizophrenia, depression and mania have a genetic component. Close family members who have mood disorders have a two to four times greater chance of having a mood disorder than those who are unrelated. The chance is higher if the family member has bipolar disorder. \(^{24}\) Hobson and Leonard note that patients with a history of mania (whom he termed bipolar) had a higher incidence of mania in their families when compared with those with recurrent depressions only (whom he termed monopolar). \(^{25}\)
Other studies since the 1950s until the present show marked differences of correlation of mania and depression within family systems. Goodwin and Jamison note:

The rate of mood disorder (major depression, dysthymia, or bipolar disorder) among first-degree relatives (siblings, parent, and children) of bipolar persons averages about 20%. On average, about 8% of a person’s first-degree relatives have bipolar disorder, and about 12% have major depressive episodes without mania or hypomania.²⁶

Twin studies provide a strong correlation as well. Identical twins average 57 percent and fraternal twins average 14 percent.²⁷

David J. Miklowitz states that medication has shown to make a positive difference in recovery for those suffering with mania and depression.²⁸ These medications fall under many categories. There are tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOs), and selective serotonin reuptake inhibitors (SSRIs). Although medications continue to improve the lives of those with mania and depression, all may include significant problems and side effects.²⁹ Typical side effects include decrease in libido or sex drive, dry mouth, nausea, headaches, and sleep problems.³⁰

Although rarely used today, electroconvulsive therapy was one of the first treatments for severe depression. Hobson and Leonard vividly illustrate how shock therapy works on the brain to reset the part of the brainstem responsible for the distribution of the neurotransmitters serotonin and norepinephrine, which were thought to be depleted or less than normally effective in depression. Shock therapy reverses that.³¹
Although electric shock therapy has been found to alleviate depression, and reduce the risk for suicide, it is used rarely due to side effects and the thought of it being an inhumane treatment.

An important aspect to consider when looking at the biological perspective of any psychological disorder is the role of substances, which often accompany schizophrenia, schizoaffective disorder, and mood disorders and share some overlap in terms of onset and genetic components. Those who are identified as having both a mental disorder and a substance dependency are classified as being dually diagnosed and given a dual diagnosis. A very high percentage of those with mental illness also have dependency issues, because, as Nace states, many people with mental illness self-medicate."  

The onset for substance dependency and the onset of mental illness are very similar. Alcohol and drug dependency usually begins between 19 and 21, while depression and other affective disorders usually occur between the ages of 18 and 25. These overlaps make it easier to be given a dual diagnosis and may create difficulties in diagnosing the primary issues. The prevalence rates of dual diagnoses among those with a history of bipolar disorder are significantly high. Nace reports:

Patients with a history of bipolar disorder will have a history of alcohol abuse and dependence in 46 percent of cases and drug abuse in 41 percent of cases. Either drug or alcohol abuse will have occurred in 61 percent of bipolar patients. Considering patients with only depression (not manic depression), 17 percent will have had a history of alcohol abuse or dependence; 18 percent, drug abuse; and 27 percent, either drug abuse or alcohol abuse.

This high correlation makes it very important to monitor substance use in mental health patients.

In sum, the research on the biological aspects of schizoaffective and mood disorders shows there is a genetic component to these disorders, especially for bipolar
disorder within families. Treatment for these disorders through medication address the chemical aspects of the illnesses as well as produce biological and neurochemical side effects. As such, medication that treats symptoms of depression, mood disturbances, and psychosis works to alter chemical imbalances but also can cause severe, negative side effects. This review also covered the strong correlation between substance use and the affective disorders. The research shows an increase in chance of substance use for those with affective disorders versus the population as a whole.

There are those that believe that the medical model of schizophrenia needs to be reexamined to better understand how to help those that are suffering with psychosis. A primary criticism is that when clients are treated primarily though the medical model and its interventions, patients and families are not allowed to take an active role in their own healing. When only the medical model is used, the leading agents in the recovery are treatments such as lobotomy, electroshock therapy, and medications.

**Cognitive-Behaviorial Perspective on Schizoaffective Disorder**

This section of the literature explores cognitive and behavioral experiences for those who suffer from psychotic and/or mood disorders. The literature and research on cognitive-behavioral approaches on schizoaffective disorder is limited but according to Folin Armfield Key, “there has been an upsurge in the investigation of CBT approaches for delusions in the schizophrenia-spectrum disorders” which includes schizoaffective disorder. As such, the focus of this section is on CBT approaches to psychotic symptoms of psychotic disorders and affective disorder, primarily depression, which is another component of schizoaffective disorder.
The underlying theory of cognitive-behavioral approaches is that thoughts create mental disturbance, which results in unwanted behavior. Treatment then entails focusing on thoughts and working with thoughts to decrease mental illness symptoms through behavioral changes. The review addresses the various cognitions found in those that suffer with these psychotic disorders, such as paranoia, and address treatment approaches that assist with faulty cognition. The forefathers of cognitive therapy, Albert Ellis and Beck are discussed as well as mindfulness from the Buddhist practice. This review also explores cognitive-behavioral therapy (CBT) and how it is used to help those that suffer with psychosis.

According to Vinogradov and Yalom, there are many cognitive disturbances that manifest in psychotic disorders and symptoms, including “the inability to filter, increased associations, distractibility, flooding, increased speed of thinking, feelings of enhanced mental capacity, mental exhaustion, slowed thoughts, and an inability to interpret and understand everyday experience.” Beck and Rector believe that emotions of the individual are also affected. The emotions are usually more intense or inappropriate for the current situation. Although the emotions may be intense and cause people in the midst of psychosis to overreact, the affect of the individual presents as more flat relative to a person who does not experience psychosis.

The most known cognitive disturbances in psychosis are hallucinations and delusions. Hallucinations are perceptions that people have that cannot be attributed to an outward cause. True hallucinations may also occur in a wakened state and be involuntary, which distinguishes them from dreaming and daydreaming according to Beck and
Rector.\textsuperscript{38} Susan E. Mason and Rachel Miller point out hallucinations are not only visual but also include auditory, olfactory and tactile sensations.\textsuperscript{39} Beck and Rector note that stressful events and situations tend to trigger these hallucinations. They describe three salient types of hallucination, those where individuals hear an ongoing narrative about their behavior, voices that comment on an individual as if he or she were a third person, and cases where individuals here their thoughts as if iterated aloud.\textsuperscript{40}

Vinogradov and Yalom define delusions as “false beliefs that patients develop to explain an experience, a sequence of events, or the nature of their relationship to the world.”\textsuperscript{41} Beck and Rector note that delusions can be of a paranoid nature or grandiose nature. They also note that delusions and hallucinations are commonly linked and better understood when discussed in relation to one another. Experiencing auditory hallucinations and delusion, such as hearing voices, leads to feeling out of control and can be very distressing.\textsuperscript{42} Fowler, Garety, and Kuipers believe that the underlying reason delusional beliefs and beliefs about hallucinations arise are from attempts by the individual to explain internal phenomena, such as bodily sensations or odd, perceptual aberrations, or even environmental stimuli, such as social situations that may be ambiguous.\textsuperscript{43}

In alignment with this idea is the notion that when individuals are given to hallucinations they lose the capacity for \textit{meta cognition}, or the ability to reflect upon their own mental processes and experiences.\textsuperscript{44} Andrew Gumley, Kevin Power, and Craig White examined cognitive models of psychosis and relapse. They write that individuals who are better able to discern what is real from what is not are usually able to identify the source of a perceived event, whether internally or externally, by applying a set of criteria.
They do this automatically and unconsciously, applying factors such as cues, context, and expectations. What influences the way an individual processes an event is styles of information processing and something specific that may be going on in the environment. When individuals hallucinate, they attribute events that were cognitively or internally stimulated to ones that were stimulated from outer events.45

Cognitive behavioral therapy is used frequently to help those that experience psychosis. CBTs focus on changing thoughts and beliefs has the capacity to reduce the psychotic experience. Fowler, Garety, and Kuipers state that the aim of the therapy is to try to determine the factors that contribute to the manifestation and maintenance of psychotic symptoms such as stressors, vulnerabilities, and responses.46 Cognitive therapy is also helpful for the therapist because it provides a therapist with concrete goals rather than a broad theoretical lens from which to work. Fowler, Garety, and Kuipers believe there are three main goals that are fundamental to treating psychosis. The first is to reduce the distress that the delusions and hallucinations are causing in the patient’s life. The second goal is to help the client understand more about psychosis and to encourage the client to engage in therapy, to understand what is internal and externally stimulated, and to increase his or her ability to cope. The third goal is to decrease the patient’s depressive symptoms, such as low-self esteem and hopelessness.47 Like other theoretical lenses, cognitive behavioral theory focuses on helping the client putting meaning to the voices and work at arriving at a more positive meaning. This aids in decreasing paranoia and other symptoms of psychosis, which allows the client to work on recovering from depressive symptoms and build coping skills.
While cognitive-behavioral therapy has begun to make inroads into effectively treating the psychotic symptoms of schizophrenia and schizoaffective disorder, its treatment of depression and mania has made major strides over the years. As Hobson and Leonard note,

This therapy [cognitive-behavioral therapy] recognizes that depressed people commonly have a negative view of themselves, the outside world, and the future. So it starts out by setting up a warm and supportive therapist-patient relationship. Within this relationship, the therapist applies logic, rules of evidence, and Socratic questioning in ways that encourage the patient to reveal, question, and correct the assumptions responsible for his or her bleak outlook.48

Beck is known as the forefather of cognitive theory, especially in relation to his model for depression. Beck’s therapy for treating depression is particularly effective due to its “structured, short term, present oriented method, directed towards solving current problems by means of modifying dysfunction and behavior.” 49 Arthur S. Freeman and John R. White note that Beck’s understanding of depression emerged out of examining factors leading to suicide and his subsequent focus feelings helplessness and hopelessness.50 Many other treatment approaches have been created based on Beck’s original work.

Another pioneer in CBT is Albert Ellis, who created *rational emotive behavior therapy* or REBT. It too works on reducing emotional disturbance through observing and understanding, disputing “irrational, grandiose, perfectionistic *shoulds, oughts, and musts* and their *awfulizing.*” 51 REBT focuses on the idea that people have control of their thoughts, which in turn changes their emotional reaction and behavior.52

Although CBT has been effective in helping those with symptoms of schizophrenia and schizoaffective disorder understand their experience and reduce their emotional distress, important aspects of their experience were neglected by these models.
A model emerged in the 1990s to incorporate what cognitive theories were thought to lack called social constructionism. Michael Mohoney views it as a way to help clients understand their unique experiences in the world. Dennis Saleeby writes about the many influences that social constructionism is able to incorporate:

Social Constructionism relies upon the more postmodern notion that how people come to understand and know, explain, and account for their words and their situations is a social and relational process, channeled by culture, inspired by language, and shaped by historical context. Our view of the world and of reality is molded by conceptions created in conversation and discourse of others as well as the historical discourse we know as culture and institution.

Social constructionism is not just a theoretical lens but is also used in therapy. Mohoney writes that there are three central themes that a therapist utilizes to help a client understand about their experience. First, human beings create their reality whether alone or in conjunction with others. Second, we all have deep central cognitive structures from which other, more peripheral ones, develop. These can be thought of as themes that are very strongly embedded in our “belief systems, culture, and behavior, and are very difficult to change” although social constructionists make them the “targets of change.” Third, our processes involving knowing, learning, and memory, “are the ‘phenomena’ that reflect the ongoing attempts of body and brain to organize (and endlessly reorganize their own patterns of action and experience – patterns that are, of course, related to changing and highly mediated arrangements with their momentary worlds.”

At the forefront of CBT approaches are those such as acceptance and commitment therapy (ACT), which incorporate the practice of mindfulness, which is a practice found in Buddhism. Mindfulness is operationally defined for the purposes of therapeutic goals as one’s concentration on bringing one’s attention to experiences occurring in the present moment experiences an attitude of acceptance, curiosity, and openness. These
practices are helpful in working with depressive symptoms. Mindfulness practice encourages one to acknowledge the thoughts and the images that flow into our minds but to also acknowledge that we are not our thoughts.\textsuperscript{59}

The literature on cognition around psychotic experiences and depression points to a strong need to use cognitive approaches when working with individuals that experience both psychosis and depression. The various types of therapeutic approaches agree that the aim is to change thought patterns, which in turn decreases negative emotion. For psychotic patients in particular, an emphasis on understanding and coping with psychotic symptoms is particularly helpful in reducing distress.

**Psychodynamic Perspective on Schizoaffective Disorder**

This section of the literature explores schizoaffective disorder through psychodynamic perspective. Limited literature from a psychodynamic lens necessitates a review on psychosis and depression through a psychodynamic approach. Sigmund Freud, the forefather of psychodynamic therapy, did not contribute much to our understanding of psychosis and depression; however, Fromm-Reichman, a German analyst, explored cases of schizophrenia, which she thought occurred in part due to a *schizophrenic mother*. Other psychodynamic theorists posit that schizophrenia results from relationships between child and family. The following review explores the thoughts of Perry, Sullivan, and Laing.

Psychoanalysis, which was conceived by Sigmund Freud in the late 1800s, is the oldest form of psychotherapy and continues to be developed today. One of Freud’s most important contributions was to posit an *unconscious*, a part of an individual that has
motives, wishes, and desires out of the realm of one’s awareness. Freud’s original model is referred to as the topographic model, in which he envisioned “the unconscious, with its inaccessible, repressed wishes, impulses, and memories, at odds with the more acceptable conscious and preconscious.”

Stephen A. Mitchel and Margaret J. Black note that Freud’s overarching theory is that the path to healing from mental illness is to become more aware of one’s unconscious desires and make forbidden thoughts conscious. He believed that these thoughts are repressed because they are deemed too dangerous or destructive by the ego and that these are at the root of mental health problems. In the 1920s, Freud gradually became aware that the unconscious impulses and desires come into conflict with defenses, not merely with the unconscious, and these defenses are also partly unconscious and aim to maintain a sense of balance. Psychodynamic theory still has at its core the idea that symptoms are alleviated by understanding the functions of one’s defenses and attempting to free the person from deep feelings such as guilt over one’s unconscious thoughts and genuine reactions to life events and the restriction of one’s defenses. In other words, one must work through one’s conflicts.

This goal has been proven difficult to achieve when working with those with psychosis. Freud himself believed that psychoanalysis worked best on patients with neurotic rather than psychotic defenses. Psychoanalysis works through the transference relationship, meaning that the conflicts that a patient has will be displaced onto the analyst and then worked through with the analyst. Freud believed that psychoanalysis works best when patients are able to have a transference with the analyst that is positive. Freud believed the analytic task is impossible with patients who have paranoia as a main
defense. Steven J. Ellman writes, “Freud took the paranoic as a prototype of narcissistic patients. He assumed that they had not formed stable-enough object relationships and were therefore not capable of forming a transference relationship with the analyst.”  

Object relationships are derived from relationships with one’s earliest caretakers that set the pattern for other important relationships. Ellman adds, “later day commentators have interpreted that Freud used the term *narcissistic* when he really meant *psychotic.*”  

Therefore, Freud believed that little progress could be made because a psychotic patient has difficulties being in reality and relating with others.  

Not much evidence supported the usefulness of having a psychodynamic perspective of psychosis until 1940 when Fromm-Reichmann, a German analyst began to explore the concept of the schizophrenogenic mother. Hobson and Leonard note that she thought that schizophrenia and other mental illnesses emerge due to being rejected at an early age. She believed that rejection from the mother made situations and the illness even worse. N.M. Zalutskaia notes that psychoanalysts such as Ammon believe strongly that the roots of mental illness begin in one’s earliest relationships. Ammon notes:

> Disturbed interaction between the developing child and his or her mother or a further primary group that is unable to support the child adequately in the development of his or her ego functions and the delineation of his or her own identity….The function of a group in the pathogenesis of archaic ego disorders becomes especially distinct in case of a symbiotic disturbance in the form of prolonged symbiosis.

This means that the child is unable to develop a sense of separate self. Studies show that rejection or loss of a parent may play a role in the emergence of schizophrenia. In 1978, Bleuler’s research of 932 people with schizophrenia showed 31 percent of the people had lost a parent before age 15. Peter Jones’ study of 5362 in 1994 supports the notion that
mothers can have an enormous impact on a child developing schizophrenia. Jones found that children with mothers with poor parenting skills at age four were more likely to be schizophrenic than children of those with adequate parenting skills.\textsuperscript{71}

Perry believes that it is essential to understand not merely how psychosis evolves in a patient, but rather it’s function in the psyche. He believes that those with schizophrenic individuals have a disordered ego, “which suffers from a constricted consciousness that has been educated out of its needed contact with the natural elements of the psychic life, both emotion and image.”\textsuperscript{72} He was interested in exploring alternative ways to work with people who have schizophrenia besides medication, locked wards, and electroshock therapy. Through his work, he stresses the vital importance “that the response from a [schizophrenic]’s surroundings be in accord with the nature of the experience he is undergoing.”\textsuperscript{73} Through validating a person’s psychosis, one is better able to work with their personal story and struggle with their environment and relationships to others.

The work of Sullivan contributes much to the psychoanalytic perspective in relation to schizophrenia and psychosis. He, like Perry, argues “that even the most strange and peculiar the delusions or hallucinations are meaningful when understood within an individual’s life story.”\textsuperscript{74} Sullivan believes that at the heart of schizophrenia is a fundamental disturbance in a person’s relational capacity, and that this is due to their early relationships.\textsuperscript{75} Harold Searles believes strongly in Sullivan’s work. He posits that therapists should use their countertransference reactions, which are basically feelings, thoughts, and subjective reactions to the transference relationship, in order to understand the patients’ core conflicts, defenses, and unconscious emotions.\textsuperscript{76} Laing, like Sullivan
examined the isolation and feelings of imprisonment that an individual with schizophrenia experiences:

The individual in this position may appear relatively normal, but he is maintaining his outward semblance of normality by progressively more and more abnormal and desperate means. The self engages in phantasy in the private ‘world’ of ‘mental’ things, i.e. of its own objects, and observes the false self, which alone is engaged in living in the ‘shared world.’ Only through a false-self system, is the individual able to communicate with others. Hence what was designed in the first instance as a guard or barrier to prevent disruptive impingement on the self, can become the walls of a prison from which the self cannot escape.  

Laing is referring to the difficulty those with psychosis have in allowing their true thought processes to be revealed to another human being. They work hard to present as normal. They adopt a false self to present to the world, but they are forever banished from true communication and intimacy. This presentation causes them to look less vulnerable when in fact they are at the most vulnerable when experiencing these altered realities. This armor that they have put on causes difficulty in letting other people into their world, which leads to isolation.

Although for many reasons psychoanalysts have found it difficult to work with patients with psychosis, the work to attempt to do so continues. Michael Eigen writes that a psychotic individual sometimes presents as cut off and at other times is very demanding of the therapist. He writes

If the worker finds his way within the patient’s force field, he becomes the target of obscurely fierce pressures. Body ego dispersal and mental control often go together, so that the patient is falling apart, yet hard as steel. . . . Therapy with psychosis must be a messy and harrowing business, one that plays havoc with the assumptive grounds of communication. No wonder Freud experienced psychosis as an assault on the rules of psychoanalysis, perhaps the latter’s truest test and limit. It is still an open question how to best meet a psychotic transference or to effect the cohesion of the scattered debris of a broken self through the formation of such an intense relationship.
Here Eigen speaks of the difficulty of working through the relationship with an individual with psychosis. The patient wants to remain removed from the therapist but on the other hand demands to be held together or contained by the therapist. Eigen states that the defense of psychosis leads to a thin ego defense and fragmentation of the ego, and as compensation a great deal of mental control must be exerted to hold oneself together. He believes the goal of psychoanalysis is to help bring the fragments of self together through the therapeutic relationship. He concludes this passage with a note of hope. The point where it looks like no progress can be made is the point where progress occurs. He concludes that as difficult and demanding as this work can be, “It is precisely where demand converges with an impasse point that psychic evolution for all may occur.”

**Sociocultural Perspective on Schizoaffective Disorder**

Although, there is minimal research that focuses specifically on schizoaffective disorder in relationship to the African American culture or Rastafarian culture, there is literature on African American culture in the context of schizophrenia and/or mood disorders. This section of the literature review looks at African Americans in relation to mental illness, including psychosis and depression. It also explores topics that relate to the symptomology of psychosis depression and within the context of their environment. It also explores other cultural environments outside of the United States and how those environments interact with those suffering from mental illness. The review also covers race specific disorders and the Rastafarian culture.

This section first addresses stigma about mental health care in the African American community and biases that create barriers in African Americans getting
treatment for mental health issues. African Americans have many reasons to not seek treatment, including past mistreatment by medical providers, who have demonstrated bias’ and misconception of their behaviors, given them inappropriate labels, misdiagnosed them. African Americans may also mistrust European Americans; these factors may have led to a natural mistrust among African toward mental healthcare professionals. In order to adequately understand the perspective of African Americans towards mental health treatment, it is important to understand the differences and the level of struggle that this culture has experienced historically. Through this awareness, providers may be more equipped to serve this population whether they are a white provider or a provider from a minority race.

Alexandria and Poussaint write that stigma towards mental health treatment plays a large role in creating barriers to African Americans getting the help they need for mental health issues. They believe it is imperative that African Americans receive help in order to work past the self-destruction that exists within. The United States Centers for Disease Control and Prevention reports that the suicide rate for African Americans is the third leading cause of death in young African Americans between the ages of 15 and 24. The second and third leading causes of death in young African Americans are homicides and accidents. These percentages are high compared to other ethnicities. It is difficult to find one core reason why suicide is so very prevalent in the African American culture. Alexandria and Pussaint believe that the high suicide rates are related to the homicide and use of substances within the population. Violence and other self-destructive behaviors may have had their origins in the trauma of slavery. Na’im Akbar writes that a feeling of inferiority “is one of the most destructive characteristics from slavery” and that
African Americans tendency towards self-hatred and low self-esteem must be considered. The feelings of low self-esteem have created difficulties for African Americans in valuing themselves and others of their own culture. Violence directed towards other African Americans is most likely related to rage felt by African Americans as part of the psychological legacy of slavery. Alexander and Poussaint write, “Some speculate that the fact that blacks most often kill other blacks reflects a twisted form of suicide.”

Another reason African Americans avoid seeking help for mental health issues is that there is much distrust of hospitals and clinics in the African American community due to mistreatment in the past. In the past, African Americans were used in research and experiments that were dangerous. One of the most famous of these experiments took place at the Tuskegee Institute. The government studied the effects of syphilis and possible cures and infected African Americans with syphilis without their knowing. Even today, the African American population may evidence paranoia when needing care for mental illness as well as for medical issues.

Another reason African Americans avoid mental health treatment is due to the biases that have historically experienced and continue to experience from psychiatrists and therapists. Judith Mishne notes there is much evidence that psychiatrists and therapists hold biases towards African American cultures as well as towards other ethnic minorities. The mental health field is comprised primarily of white providers, who are vulnerable to the cultural biases that is embedded in the U.S. culture; such biases towards African Americans may prevent these practitioners from providing the best treatment. Even African American providers may demonstrate biases towards the African American culture. Gardner states “that even black doctors are not immune to such bias, because
when they don their physicians’ white coat and enter a predominant white world of health and mental health care givers, they often don its values too.” 93

These biases have led to these African Americans being given disorders that white cultures have not been given. In the nineteenth century, Samuel Cartwright coined the disorder *dраНетомания*, which was considered a disorder that caused slaves to run away. The disorder *cannabis psychosis* and *Caribbean psychosis* were disorders used to identify use of marijuana in the black culture. 94 Bentall, Mosher, and Reed discuss McGovern and Cope’s research on cannabis psychosis in 1997. They state, “In one study, male Afro-Caribbean inpatients were 95 times more likely than White male patients to be diagnosed ‘cannabis psychosis’” 95 Bias can also be found in the misdiagnosis of African Americans with disorders that are found in the *Diagnostic and Statistical Manual of Mental Disorders*. African Americans are more likely to be diagnosed with schizophrenia than Caucasians. Mishne writes, “The same symptoms that are generally labeled as due to emotional of affective disorders among whites are often attributed schizophrenia in among blacks.” 96

Although making differentiations between cultures in order to diagnose them can be problematic when these distinctions are made due to the clinician’s bias, it is also important to be aware of these unique aspects of culture when treating an African American individual. For example, C.R. Ridley coined the concept *confluent paranoia* in 1984, which describes the “interaction of cultural context and pathological symptoms.” 97 Brittany N. Hall and Arthur Whaley conducted research on African American psychiatric patients and confluent paranoia and found that the patients who were categorized as
having confluent paranoia tended to display symptoms that were more severe when compared to those who were not given such a classification.\textsuperscript{98}

Hall and Whaley suggest two approaches that may be helpful in examining the interaction between psychopathology and culture. The first model, called \textit{additive interactions}, is when cultural issues and symptoms of pathology may both be present but are separate from one another. The second, called \textit{multiplicative interaction}, involves cases in which cultural and pathological features are actually intermingled.\textsuperscript{99} The most severe symptom that African Americans experience due to confluent paranoia is delusional thinking. The delusions are usually persecutory and thought to be related race-related issues.\textsuperscript{100} Awareness of this phenomenon can lead to better therapeutic approaches and interventions to assist in mental health treatment.

Like the concept of confluent paranoia, the following race-specific diagnosis is not a negative bias but a way to better understand the African American culture. According to Alexandria and Poussaint, \textit{posttraumatic slavery syndrome} is the outcome of “a culture of oppression, the byproduct of this nation’s development has taken a tremendous toll on the minds and the bodies of black people.”\textsuperscript{101} Therefore, it is important for clinicians to gain a better understanding of the struggles that occurred during slavery and have continued to occur in the aftermath of slavery in the many decades that followed.

Slavery created a huge negative impact on the African American population, but there are those that believe that there may be mental health advantages from having endured it. Many people have researched the idea that African Americans are less affected by mental health disorders due to their \textit{Africentric worldview}. K.W. Allison and
F.Z. Belgrave identify “the following dimensions of an Africentric Worldview: 

**spirituality** (belief in a being or force greater than oneself); **collectivism** (emphasis on cooperation); **time orientation** (equal importance attributed to past, present, and future and time flexibility); **orality** (preference for receiving stimuli and information orally); **sensitivity to affect and emotional cues** (acknowledgement of others’ emotional and affective states); **verve and rhythm** (rhythmic and creative behavior); and **balance and harmony with nature** (balance between one’s mental, physical, and spiritual states).”

It is believed that these cultural ways of being developed in Africa and have been passed down to the generations that came to America. These cultural ways of being are thought to have been essential for survival for Africans that were enslaved. They continue to be essential to current survival and coping with mental health issues. Akbar suggested that “any deviation from an Africentric Worldview could be equated with a disorder or psychological dysfunction.” The importance of looking at how culture affects resiliency and mental health positively is just as vital as looking at how it affects it negatively. Of particular importance to this case study is how the Rastafarian culture may interact with an African American in the mental health system.

Many African Americans have adopted the Rastafarian life due to its appealing ideology. Rastafarian culture originated in Jamaica although it was created from the ideas of a man from Africa, Halie Selassie. His formal name was Ras Tafari Makonnen, and he was crowned Emperor of Ethiopia in 1930. Black nationalists, such as Marcus Garvy, saw in him a “powerful black man who possessed the capacity to restore to African peoples their respect, rights, and dignity.” The Rastafarian culture first emerged in Jamaica, when it was under the rule of England. Leonard Percival Howell believed that
Jamaicans should show their loyalty to Ethiopia and not England because they were Black. In 1931, Rastafarian, a religious-cultural group, developed the following list of beliefs. First, they believed that the Messiah had returned. Second, they believed that the primary experience of black people in the West had been subjugation. Three, they believed that England could not expect allegiance from them or had any right to tax them.\textsuperscript{106}

The Rastafarians came into conflict with those who were invested in upholding the more established ways of Jamaica as their beliefs began to be embedded into the culture. Charles Reavis Price writes that the Rastafarian culture’s orientation, which was antisystemic, created archetypal rifts in the Jamaican culture as a whole. The main rift was between Rastafarians who were anticolonial and those in society, both Black and White, who were colonial. What’s more, their pro-black views came into conflict with most Jamaicans’ view of what it means to be Black, and their new religion seemed to threaten older, more established ones. Finally, Rasafarian change agents were pitted against the police and the establishment, or law and order.\textsuperscript{107}

Out of the continual oppression that Rastafarians experienced, Reggae was created. Reggae was a way to musically express and communicate Rastafarian ideas.\textsuperscript{108} Cannabis or Ganja also played and continues to play a large role in the Rastafarian culture. Jamaica’s land is very conducive to growing cannabis and many Jamaicans smoke, eat, and drink the herb. The British government quickly realized that they could put taxes on the sale of cannabis and sentences of up to five years were given to those who did not obey.\textsuperscript{109}
As the new generation of Rastafarians came of age in the 1950s and 1960s and more changes occurred. Price writes that by the 1950s the Rastafarians had a unique identity with many distinctive features such as language, diet, an attachment to Africa that superceded that of a national attachment, the use of cannabis, and dreadlocks, which are hair that remains uncombed in long tresses. They also emphasized communal living and a sense of independence.\textsuperscript{110} In the 1970s many African Americans found the movement appealing and joined. It was seen as embodying a powerful and positive expression of what it means to be Black.\textsuperscript{111} Although many Rastafarians from Jamaica do not believe that American Rastafarians are true Rastafarians, the number of Rastafarians in America continues to grow.\textsuperscript{112}

The review of the literature pertaining to African American culture was intended to create a better understanding of why many in the African American population may experience many mental health issues and avoid treatment. There appears to be agreement among researchers that that the African American culture is in need of appropriate treatment that can only come from better awareness of the culture on the provider’s side. This review was also meant to differentiate between negative and positive syndromes, concepts, and disorders that have been given specifically to this culture. Understanding the concepts or syndromes such as confluent paranoia and posttraumatic slavery syndrome may lead providers to a better understanding of how to work with their clients or patients. It is important to recognize that many African Americans experience self-hate and low self-esteem due to the psychological legacy of slavery. The review of the Rastafari culture illustrates a movement that helps to counter internalized self-hatred by emphasizing black strength and black pride. It is also a culture
that emphasizes self-reliance and so does not encourage one to readily admit deficits or accept help from the white population. This creates another barrier for some African Americans to get treatment for their mental health issues. A gap in the literature is information on the relationship between Rastafarian culture and Western notions of mental illness. More research on this topic is needed to better serve this population.

When viewing mental illness through a sociocultural lens, it is important to keep in mind that other cultures have much different ways of managing mental illness and that Western practices may not always serve patients with psychosis in such optimal ways. Examples abound. Paul Fleishman went to India and observed people with schizophrenia. They were not receiving the same kind of care that is found in the United States but were doing quite well.\footnote{113} Fleishman believes it was because they have families. They are not subdivided into a separate class of society; they spend their days not in alien fluorescent-lit hospital rooms but sitting on charpoys in the shade of the earthen walls of their family home, surrounded by the hubbub of joint familial life yet tactfully excused from it.\footnote{114}

In addition, in African culture, mental illness and psychosis are not viewed as originating from chemical imbalances but from other issues. In Zimbabwe, spirits that cause psychosis are called ngozi.\footnote{115} Kanyiswa Mzimkulu and Leickness Simbayi write about how African traditional healers worked with someone with psychosis. Psychosis is thought to have to do with either the patient or the patient’s family breaking a social taboo. Psychosis is caused by the anger of the spirits at the patient or family. T.J. Scheff believed that projecting the illness onto the spirits allows an \textit{aesthetic distance} from the patient and his or her illness.\footnote{116} The illness is seen as independent of the person suffering from it and this, perhaps, helps facilitate its removal in a way that leaves the person intact
and whole. The ways in which mental health illnesses are viewed from more spiritual perspectives are further explored through imaginal approaches.

**Imaginal Approaches to Schizoaffective Disorder**

This section of the literature review addresses schizoaffective disorder through an imaginal perspective. Due to the fact that schizoaffective disorder is largely believed to be a biologically-derived illness, this section of the Literature Review offers a countervailing approach. It provides an understanding of how an imaginal approach could be utilized to understand schizoaffective disorder by looking at how it approaches schizophrenia and mood disorders, most specifically depression. Imaginal psychology addresses many focuses, which may overlap with other perspectives in this review. This section of the review begins with a focus on Jung and archetypes. Then literature pertaining to ancient cultures of Greece and Rome in relation to mental illness is reviewed. There is also an exploration of Greek and Roman myth. Finally, the review examines an example of mental illness existing in less modern societies.

Jung did not believe that mental disorders were a result of deficits in one’s brain chemistry. According to Dehing, Jung believed that mental disorders, such as psychosis, develop due to difficulty containing strong emotions.\(^\text{117}\) Jung believed that psychosis occurs when one’s ego-consciousness becomes submerged, or taken over, by an archetype. Archetypes are powerful structural components of the mind that stem from “the accumulated experience of humankind.”\(^\text{118}\) Jung’s belief led him to explore in depth mental disorders in relation to these archetypal forces.\(^\text{119}\) Much of Jung’s exploration around archetypes and the unconscious was through his work with
schizophrenic patients. Dehing notes that Jung believed that patients suffering from schizophrenia are lost in magical place where they witness to repetitions of a story that is told endlessly and where time seems to stop. He notes that it was through archaic forms of associations he heard from schizophrenic patients that originally gave him the idea that there was such a thing as an unconscious that was other than one that contained traces of one’s personal history that were once conscious. Jung describes the similarities between psychosis and dreaming. He posits that the closest way to describe schizophrenic thinking is to compare it to a dreaming state. The dream state occurs while sleeping and the psychosis occurs when awake. Jung’s way of looking at psychosis is different from other theoretical approaches that are used today but his perspective includes the element of image and consciousness which other perspectives lack.

Many ancient cultures struggled to find reasons and cures for mental illness. The *humoral theory* created by Hippocrates and his followers held that humors, which were bodily fluids, were the cause for mental and physical illness. Morgan Hunt notes the theory proposed, “When internal or external factors disturbed the balance of the blood, phlegm, yellow bile or black bile in the body, the imbalance led to insanity.”

Evans, McGrath, and Milns discuss Celsus, an early psychological theorist who attempted to discover the differences between psychosis and delirium. He related delirium to general medical conditions. He viewed delirium in patients with fevers and noticed that it only lasted a short time. Celsus distinguished between three types of insanity for which he identified appropriate treatment. The first type might be interpreted today as delusions. These were imaginings he characterized as vain. He said that patients with this type of insanity might be sad or filled with laughter, might exercise a great deal
of control, be violent or rebellious, and could do harm because of loss of impulse or on purpose. Celsus believed that this type of insanity was found mostly in patients with fevers. Celsus’ second type of insanity was thought to be the illness of depression. His third type of illness was thought to refer to mania. In this latter type, patients could be physically sound but be mentally ill for life. Celsus believed that the third type of insanity was severe and hard to treat due to the resistance of the patient. He also believed that a psychotic and/or manic state could be predicted by noticing if a patient began to talk faster and/or was more volatile.

Throughout the literature of ancient Roman and Greek culture, there are many examples of madness. This literature ranges from historical accounts to poetry to plays. Evans, McGrath, and Milns discuss Euripides’ play Orestes. The protagonist of Orestes is beset by both hallucinations and delusions. Other historical figures were identified as having “‘maddness’, ‘hallucinations’, or ‘phantoms.’” It is difficult to separate out in historical accounts what is mental illness from what are visions. For example, Plutarch discussed Brutus’ experience with seeing phantoms and indicated that both hallucinations and delusions are experienced by those who are deranged, but that people may also have visions that are true and are not the product of mental illness. Evans, McGrath, and Milns note another example of delusional thought which can be seen in the myth of Ajax. Ajax was one of the most famous warriors of the siege of Troy. He was supposed to receive the amour of Achilles and when he did not he became very angry. He was thought to have had delusions, which caused him to kill a flock of sheep that he thought were the Trojan army.
As described in Brutus’ experience, there has been debate over whether psychotic experience is a mental illness or a form of mysticism. Laing believes that the psychotic “is thus on a profound, dangerous, mystical voyage whose purpose is to find new, deeper ways to communicate. The psychotic isn’t content with the ordinary ways of knowing that the ego offers, any more than the religious mystic is.”

In the 1990s, a study at Oxford was conducted that consisted of 5,000 separate accounts of psychotic and religious experiences. The findings showed that individuals dealt with their experiences based on how others value their experiences. John Foskett, a British pastoral counselor, believes “that a purely psychiatric approach which explains [the experiences] in terms of dysfunction may actually be instrumental in producing pathological symptoms.” Over the past two decades there has been increasing awareness that the profession of psychiatry involves spirituality and more and more people of the profession are practicing this now. Russell Shorto pointed out that “psych mean “‘spirit’ or ‘soul’. And psychiatry is, etymologically, soul doctoring.”

The literature from the imaginal approach looks beyond conventional notions of mental illness as being caused by deficits linked to brain chemistry or dysfunction in family dynamics. Rather, it suggests that ‘mental illness’ could come from a more spiritual or unconscious state. Through looking at other cultures past and present, it is apparent that there are many people who would believe that mysticism and spiritualism play a large part in symptoms of mental illness.
Conclusion

Reviewing schizoaffective disorder through many lenses makes it clear how complex this disorder is to understand and to treat. The importance of holding all of these perspectives in mind when working with clients or patients is essential to their treatment. Although it is inevitable that there will be some conflict between these differing perspectives, for the most they offer a firm foundation of knowledge that helps to impart a central explanation of what schizoaffective disorder is, its modalities of treatment, and its causes.

The biological perspective is, of course, much more science-based and it alone does not provide all the information that can possibly be useful in understanding and treating the disorder. The cognitive/behavioral perspective provides useful information about how the cognitive processes are affected and can be altered to aid in treatment. The cognitive perspective is very compatible with the biological perspective in that it takes into account biological evidence. In fact, medication treatment, along with cognitive-behavioral therapy, is recommended treatment according to much of the literature reviewed from this perspective.

The psychodynamic perspective focuses on the exploration around family dynamics and psychotic states and provides an alternative way to look at schizoaffective disorder. The psychodynamic perspective is more concerned with relational approaches to treatment and is able to articulate the difficulty therapists have when grappling with patients with psychotic disorders. However, there is still minimal research from the psychodynamic perspective on schizoaffective disorder, most likely due to the fact that
schizoaffective disorder and schizophrenia is primarily viewed as a biologically-based disorder.

The literature from the socio-cultural perspective reviews the various biases and stigmas that those of African American heritage deal with on a daily basis. The way that mental health providers have diagnosed and misdiagnosed this population and the effect that biases have on African Americans is important to consider when treating African Americans. The literature on Rastafarian culture gives insight into the influence of a culture that has inspired many African Americans. It offers a countervailing approach to feeling oppressed, and the movement embodies positive attributes of black culture. The socio-cultural perspective also offers important examples of ways to treat psychotic individuals that may preserve their dignity, connection with families, and sense of wholeness.

The imaginal perspective provides alternative ways to view mental illness. The exploration of ancient Greek and Roman culture provides insight into the development of diagnosis and use of science to explain thought and behavior. The review of literature that shows how closely religious experiences resemble psychotic experiences raises questions about the narrowness of biological perspective.

This review is meant to provide information through many perspectives on schizoaffective disorder in order to better understand this disorder. The review shows the strong need for research specifically on schizoaffective disorder from these five perspectives. Although there is limited research that addresses this disorder specifically, there is a vast amount of information that addresses psychosis, mood disorders, the importance of looking at culture when treating African Americans. The review of this
literature is especially important to understanding the client that is at the center of this case study.
CHAPTER 3

PROGRESSION OF TREATMENT

This chapter describes the progression of the clinical case study’s subject Marcus and his treatment. It is hoped that the reader will have a sense of seeing the client through my eyes, which is really the essence of what a clinical case study is – to see and feel the client’s experience, through the perspective of the narrative voice of the therapist.

The Beginning

In August of 2007, I was approached by Dr. John Thompson, another case manager, about a difficult and complex client he wanted to transfer to me. This had become a common occurrence as it was my job to work with the clients who needed extra support and outreach in the community. The other case managers on my team had larger caseloads, and their focus was on working with clients with fewer needs, while I had a smaller caseload of clients with more severe needs. I have always been interested in working with complex cases and those with severe symptoms, and I was finding that I really enjoyed this specialized position.

In August of 2007, I met with John to learn about the client. The client’s name was Marcus. He was only 28 years old, which was younger than most of my clients. Marcus was an African American who was born in San Francisco. He identified himself as Rastafarian. John reported that Marcus has issues with women and also with
Caucasians. I was feeling a bit intimidated by this information but I felt I was ready for the challenge. Marcus had been diagnosed with schizoaffective disorder and it was reported that he drank and smoked marijuana a great deal. He had also been reported fighting a lot recently. The previous week, Marcus broke his foot and his eye socket had been injured in a fight. He was experiencing double vision but was receiving care from University California San Francisco Hospital. Marcus also was in the process of potentially being evicted from his supportive living hotel due to the flooding of his apartment. He had passed out when intoxicated and left the sink running, and, as a result, he was being charged for the damages. I planned to meet Marcus the next day.

The nursing manager, John, and the director of the clinic surrounded Marcus when I first saw him in the cramped, tiny nurse’s station. The nursing manager was examining his eye. They all seemed very familiar with Marcus, which made sense, since he had been with the clinic since he was 20 years old. From what I had heard, Marcus had been a pet project for many clinical case managers. I wondered what was so special about him. I noticed that he was wearing a colorful wrap on his head, and he was dressed in a big sweatshirt and somewhat baggy jeans. His eyeball was full of blood and the flesh around it was puffy. He wore a cast on his left foot. I had to turn away because I tend to get faint when I see blood. I heard Marcus tell the three that he was told he might have to have his eye removed due to the severity of the damage.

John introduced me by saying, “Marcus, you know how I was telling you that I had a case manager that wanted to work with you. This is a very special opportunity for you because Jackie can leave the building and spend more time with you. We feel that
you deserve this.” There is always some concern that clients may feel abandoned when they are told that they are switching case managers, and much thought goes into how this is presented to the client. Marcus did not seem startled by this news. Marcus nodded and said hello in a soft voice that was difficult to hear. I ask Marcus to meet with me in two days, which was when he was due to pick up his weekly bubble pack of medication.

Marcus arrived two hours late for the appointment. We sat in one of the three meeting rooms, which were small and the lighting was abrasive. All three rooms had two chairs and a table with a box of tissues sitting on it. There was a plastic framed picture hanging in each one. I found these rooms cold and uncomfortable. The walls were thin and I could hear everything the client and clinician were saying next door. I found myself anxious because I knew that they could hear me too. I hoped I did not sound incompetent.

Marcus seemed quite comfortable in the room. On that day, he wore no head wrap. His many dread locks hung past the middle of his back. They were neat and clean. Marcus smelled strongly of tobacco and some other scent that I associated with incense. The odor took over the entire room. He did not appear to be anxious about meeting me. I figured he has had three or four case managers in the past eight years, and guessed that this was not anything new to him. Marcus was difficult to understand; he mumbled and his voice was soft. He did not maintain good eye contact with me, which was fine because I did not want to look at his bloody eye. He explained that his wrist may be broken and that they would be doing an X-ray the next day. He still had double vision. He was afraid of the possibility of losing his eye, but he expressed this concern without emotion.
I realized that building a rapport with him might be more difficult than I previously thought. Usually, when a client is admitted there is a very long assessment where they are asked many questions about their symptoms, their lives, their substance abuse history among other important factors to inform a clinician of a case. I did not have the luxury of doing this and I did not want to come off to Marcus as though I knew him when I really only knew what I had read in his file. I also did not want to alienate him by asking about his recent substance use or his mental health symptoms, so I refrained from asking. I did ask Marcus if I could visit his home. I told him this was something I usually do with clients. He agreed but with little enthusiasm.

A few days later I went to Marcus’ home. He lived in a newly built, modern low-income housing building. Disregarding the individuals who graced the courtyard engaged in smoking, who apparently had led a hard life, one would think this was a building full of apartments that ran $1,500 dollars for a studio. The courtyard was surrounded by bamboo and a small stone waterfall was splashing water into a tiny pond filled with water lilies. Out of the five or six individuals sitting in the courtyard, three wore disability bus passes around their necks. Over my next many visits, I would discover that this was the meeting area of the residents of the building. The more time one spent there, the more one learned the building and its residents.

Marcus opened the door when I knocked. I was impressed with the size of his room, which was bigger than my first studio in San Francisco. Attached to the room was a large bathroom that was designed for an individual in a wheel chair. A towel covered the mirror over the sink. There was an open kitchenette with a gas stove and sink. A table with a television on it stood next to the chair I sat in. The contents on the table included
loose tobacco, a lighter, rolling papers, and small pieces of marijuana that were barely visible. Marcus sat on a day bed that was against the opposite wall. A sheet hung over the window. The odor that Marcus brought into the room the last time we met was much stronger in his home. It smelled like a hippie shop on Haight Street that sold trinkets from far away countries. I felt somewhat uncomfortable sitting in his room, but I was not frightened. Marcus appeared too withdrawn and introverted to do anything harmful to me.

I asked Marcus how he was feeling physically and he said he was still in pain and was continuing to see the doctor regularly. He indicated that he may not have to have his eye removed but did not know for sure. Marcus became quiet. I am not one to beat around the bush so I decided to get a few things out of the way. I said to Marcus, “I want to let you know that I know that I am not John and I am unsure of how you feel about me being your case manager now. I also was told that you have problems relating to women and white people. I realize that I am both and that this may cause problems with us working together. I want you to feel open to discuss problems you are having with this and I hope we will be able to work through them.” Marcus said he did not really care that I was his new case manager, but he did acknowledge that he has issues with women and white people. He said that he had never had a woman case manager before. Marcus agreed to bring up any problems he might have around our differences. I felt some relief about getting possible barriers to our treatment out in the open.

There was a knock at Marcus’ door. He did not appear startled. He informed me that his mother was here to help him clean. He let her into the room. She was nothing like I expected. I had pictured her to be a tall, full-figured woman, wearing a colorful dress
printed with African designs who said little but whose words were loaded with wisdom when she did speak. She was not this at all. She wore very tight jeans, a tight leather coat, and a low cut top. She was loud and talked excessively about how much she does for her son. Marcus was quiet and seemed to fade into the corner. Marcus agreed to meet the following week and I excused myself.

However, Marcus did not appear for his appointment the following week. I called him several times for a week. The phone line rang busy or he did not answer. I finally reached him the following week. He reported having had many doctor appointments the past week. I had a feeling that this was not the real reason he did not come to the clinic. I suggested he come in to clinic the next day but he wanted to meet at his home. I agreed to meet him at the park so that he would not be able to isolate at home as I assumed he had been doing all week. Marcus agreed. We were to make many such compromises as to where to meet over the next many years. I found that I would have to be flexible based on Marcus’ needs and not expect that there would always be a set routine.

Treatment Planning

Our agency and all other mental health and substance treatment programs use a standard treatment plan form for each client. This form must be filled out at least yearly. The client is to help us to create the treatment plan, which is designed to be a collaborative process. This is not always possible due to certain factors. The client may be too psychotic to participate or the client may choose not to participate in which case the therapist completes the treatment plan and asks the client to sign it, which is not always possible. I did not immediately go through this process with Marcus. We had too
much to sort through to write up a formal treatment plan. The treatment plan would come later.

Although the official treatment plan did not take place, an informal one came to life around our third week of working together. I did not want Marcus to feel overwhelmed so I presented only two goals that we would work on. One was that he would address all his medical needs, such as attending appointments, follow the set medication regime, and follow all other related orders. For the second goal he was to maintain his housing in the support service hotel. I agreed to work with the manager on creating a payment plan to repay Marcus’ damages, and Marcus agreed to be more aware of his surroundings and the consequences of his drinking and smoking marijuana. Both goals required Marcus to decrease his substance use. Marcus agreed to these goals. I did not quite feel that he was strongly motivated or enthusiastic about these goals but rather was agreeing because he felt that he had to agree.

These two goals were concrete in ways that the other treatment goals we were to work on were not. The other goals were ones that I did not initially share with Marcus. They were goals that I wanted for him to accomplish and I believed that he needed to trust me more before committing to them.

The first of these additional goals was to reduce auditory and visual hallucinations along with his symptom of paranoia. The intervention would require Marcus to be medication compliant, to be open about his symptoms in sessions, and to be willing to learn ways to cope with his symptoms. I needed to know what Marcus was experiencing on a day-to-day basis in order to help him. I also knew he needed to trust me before he would be able to share these experiences. I knew if I pushed for information about his
delusions, I could easily become part of his delusion in a negative way. In order to avoid this outcome, I asked general questions such, as “How is your physical health? How is your mental health?” and left it at that.

The second additional goal was to reduce his substance use. To achieve this goal, I felt it would be important to build trust first. I pointed out that substance abuse leads to negative consequences and made light suggestions at the time but would address this goal more in detail later.

The third goal would be to have Marcus create a structure and a support system that would benefit his symptoms. This would include more involvement in groups at the clinic, a vocational program, and/or volunteering, which would decrease his isolation and give him purpose.

The fourth goal would be continued support relating to budgeting and finances. I would take over the payee duties from John Thompson. Marcus would have his rent paid each month plus have his payments towards water damage made. He would then have the remaining balance divided in four and would receive a check weekly.

When Marcus’ life became less chaotic, I was able to review these goals with him with the hope he would participate in meeting them. I was also able to review these goals with his psychiatrist, my team, and my supervisor, which allowed me insight into setting objectives and interventions. Marcus was aware that I was sharing these goals along with other information regarding his treatment with my coworkers. He understood this sharing of information was to support him in meeting his goals.
The Therapy Journey

Throughout our journey together, I played many different roles for Marcus. Sometimes, I was the mother saying “no.” Sometimes I was the older sister giving relationship advice. Sometimes I was the friend who laughed at his jokes and discussed upcoming music events. Sometimes I was the teacher informing him of the consequences of using marijuana while he continued to experience high levels of auditory hallucinations. Sometimes I was the student who was being taught the Rastafarian traditions. Sometimes I was the accountant helping him budget. Sometimes I was the case manager setting up his appointments. Sometimes I was a power hungry white lady holding his money from him and bringing him down. Most importantly, I was the therapist helping him process his sadness around who he had become. Although sometimes, I did not always play the right role at the right time, I do believe that my ability to hold boundaries and be reflexive was what made our relationship work.

Within in the first couple of months, Marcus’ body began to heal and he was able to start making the payments for the water damage. Our appointments were sporadic and he did not always come to them. He would come to get his check on his set check day, which was also when he picked up his medication. He picked up his medication weekly in a bubble pack, which was a package with small compartments that divided his medication by days and times. This was to ensure Marcus took his medication at the right times and every day. It the past, taking his medication at appropriate times daily had proven difficult for Marcus.

About a month after we started working together, Marcus came to the clinic to see me without an appointment. As soon as I saw him, I knew he was intoxicated; he
appeared to have been drinking and possibly smoking marijuana. He had a wild look in his eye, which told me to tread lightly. This was the first time I began to see a correlation between Marcus’ states of mind and how he wore his hair. I was later able to gauge his state of being by simply noticing his hair. He probably had thirty or so dreads and that day they were flying wildly around as he made jerking motions. When he calmed down, they fell in his face but his intense glare was clear and present.

Marcus demanded, “I want all my money now.” I reminded him that he gets one check a week and this system was put into place years before I came into the picture. Marcus spoke loudly and continued to demand his money. Marcus sat in the chair by the door while I sat with my back to the back wall. It crossed my mind that this could escalate to a violent episode but I was not afraid. It is rare that I become truly afraid of my clients who display aggressive behavior. I have been told that this is a good thing but have also been told that it might possibly not be a good thing. All I know is that showing fear feeds power. I also knew that Marcus had no violent history with case managers or in the clinic, which made me feel safer.

Marcus admitted to drinking and smoking marijuana that morning. I thanked him for his honesty and continued to focus on holding a boundary around the money. He accused me of power tripping. I let him speak his accusations but held my ground. This would not be the first or last time a client tried to accuse me of “power tripping.” Marcus became more and more frustrated and literally appeared to fly out of the room with his dreads trailing two feet behind him. It dawned on me then that holding his money was really going to be an on-going issue throughout this journey.
In December, about four months after we started working together, a shift in our journey began to take place. Marcus’ life started to crumble. His father passed away from a sudden heart attack. Marcus delivered this news in a very flat tone and refused to talk about it besides saying “I am sad.” Marcus’ older brother also had been staying with him and would not leave although Marcus wanted him to leave. I had met his brother before. He was tall, thin, with very light skin. He, too, wore dreads but they were not as long or thick as Marcus’. He was a very talented painter who used these talents to portray San Francisco urban culture. He was also a heroin addict and homeless due to his addiction. Marcus reported that his hallucinations increased dramatically when his brother was around.

During this period of time, Marcus began to open up about his mental health issues. He also started to really decompensate. He discussed his auditory hallucinations. He indicated he heard around five different voices, which he did not recognize as anyone he knew. The voices were degrading and told him that he was “stupid,” “crazy,” and “to kill yourself.” He said they were annoying but he did not read too much into them. Marcus also believed that there were people looking at him through the mirror and that there was a man that sat outside his window, which explained why he kept both covered.

I found this really interesting. I enjoy listening and working with people’s delusions and identifying similarities between them. There appears to be a general theme around being watched. I encouraged him to discuss it and he did. He had vague ideas of who these people were but did not feel they were safe.

Marcus would stop every once in awhile and laugh. I asked him why he was laughing, and he said that he knew he sounded stupid and crazy. I looked in my
intervention toolbox and pulled out my response to delusional people who commented on themselves sounding crazy. I explained that I believed that his delusions were true because they were his reality. He was experiencing these delusions as real. I told him that I wanted to help, but because I could not experience his reality, he would need to share it with me. He seemed really receptive to this intervention. He began to share with me how he sometimes became very lost in his delusion and he sometimes did not know the difference between real images and hallucinations. During these times he did not leave his home. When he was not in a psychotic state, he acknowledged the difficulty of being in a place mixed with reality and what he could recognize were imagined ideas. During this period of time, Marcus really confided in me his experiences and our relationship became strong.

He was paranoid but also aware of himself as being mentally ill. Marcus let me know that he suffered a great deal of stress over having psychotic symptoms. He did not want anyone to know about them. He hid his voices and delusions from others. He had specific ways of doing this and his identification with being a “stoner” played a large role in helping him hide these symptoms. He smoked marijuana constantly or pretended that he did. This allowed him to appear aloof and “out of it.” If someone called his name, he would not respond. He admitted to me that, at times, he was not able to distinguish whether it was a person or one of his voices calling him. He used being high as an excuse for seeming to be unaware of his environment.

I was impressed by his ability to formulate such an effective strategy to cover up his symptoms. I also acknowledged the amount of stress this must cause him. He answered, “Yes, it really does.” His reply was so honest and so sad. It seemed to come
from a place of feeling heard. I was truly touched by our interactions that day and I was flooded with feelings of sadness for Marcus.

These interactions brought up similar feelings I experienced when working with teenagers with emotional disturbances. I felt quite sad when young people, who at that age had a right to feel such hope for life, began to acknowledge how their mental illness would be such an identifying factor for their entire lives. In contrast, I have observed that many older adults, who having lived with their reality and usually having accepted it somewhat, either find coping skills to manage their symptoms, or are so out of touch with reality they do not know what is the truth.

Marcus reminded me of the teens. I could see him giving up on having a normal lifestyle. This is when I decided to encourage him to develop other identifying factors besides “being crazy.” This became part of an ongoing intervention and was integral in his ability to accomplish many of his goals. It was important for him to acknowledge that yes, he was mentally ill, but he was a lot of other things too.

Meanwhile, Marcus continued to engage in power struggles with me over his money. He constantly owed people money. Based on what he reported to me, he would get his check, pay people off, and then be broke again. Marcus also had an expensive habit of buying only meat that was halal, which requires it to fall under strict Islamic dietary guidelines. He constantly owed money to the market that sold these meats. He was stubborn about his budgeting habits and stated that he felt degraded when I offered to help him budget or explore cheaper ways to eat.

I was becoming exhausted around our power struggles over his money. I also felt defeated, because we had done such good therapeutic work and now we had relapsed into
this phase of him missing appointments and being angry with me about money. He only contacted me when he was sick and needed me to drop off his medication, when his medication was making him drowsy, or when medical issues needed to be addressed. He was resistant to coming to the clinic to see me and made excuses. During this period, I went to see him at his home. I wanted to help him but I also inwardly wrestled with how to help him, because he did not seem to want me to help him. All of my efforts to engage with him appeared to be superficial and of little therapeutic importance.

When I would deliver his medication or money, I noticed his room was messier and his appearance more disheveled than in previous visits. He was shut down and I could palpably feel his anger towards me. I did not ask him about it though, and I am not completely sure why. I noticed twice that he had left his burner on. He told me he lit his cigarettes on it. He also left food, such as mayonnaise, eggs, and raw chicken out. I expressed concern but he responded like a teenager by saying “I know. I will fix it” in an exasperated tone; and I knew he would not. I felt very uncomfortable treating a man one year younger than myself like a child. I think Marcus knew this made me feel uncomfortable also. I also believed that he used this knowledge to manipulate me about his finances during the upcoming months.

Around February of 2008, approximately eight months after I started working with him, Marcus’ depression and isolative period seemed to lift and what could be considered manipulative behavior seemed to increase. My feelings of “poor little Marcus” begin to mix with “that sneaky little –.” Marcus came to tell me that he was going to Florida to visit some old friends who were close to his father. He said that he would be staying with them. He requested all of his checks. I was a little concerned but I
knew Marcus lived in Florida for several years with his father so I thought that he would have support there. In addition, I really did not feel I had much say in the matter. I signed over all four checks to Marcus, and I also had a psychiatrist sign off on several weeks worth of bubble packs.

I did not hear from Marcus although he promised to call and check in a week after arriving. After two weeks, I became a little worried. I called his hotel to see if he had returned but they were unaware that he had left in the first place. I called Marcus’ home phone and he answered. He told me that he did not go to Florida because his friend was unable to pay for his ticket. I felt betrayed, naïve, and was furious with him. I could not even process this with Marcus. The worse part of it was that I sensed that he knew I was angry and I believed that he felt as though he possessed power over me. I can only assume that he enjoyed feeling in control of the relationship. Although some might call this intuition of mine paranoia, I was convinced at the time and continue to remain convinced that this was the case.

During March and April, a major power struggle was taking place between us over his money. He wanted all of his money given to him at the beginning of the month. I refused based on his continued heavy use of substances and his history of poor budgeting. I continued to give Marcus a check weekly. I had already broached with him my disappointment about him not going to Florida and not letting me know. Marcus behaved as though he were unaware of any problem with what he did. I continued to be angry and my sentiments played out in our interactions.

The sessions around money ended suddenly in April when Marcus was evicted. Marcus’ habit of leaving the burners on had resulted in two small fires. I have to admit
that there was a part of me that was glad that Marcus would have to deal with the consequences of his actions, but I still went beyond the call of duty to help him to fight the eviction. I also needed to do work discovering the reasons I was glad that Marcus was going through a hard time. I wondered, was I still angry that he had deceived me? I wondered whether I enjoyed his having to be dependent on me.

Perhaps my guilt over my being secretly glad over his eviction motivated me to try that much harder to prevent the eviction. I tried everything to convince the manager to let him stay. I had a meeting with the support program, and I made referrals for dual diagnosis treatment for Marcus. I thought that if he completed a program that perhaps the hotel would let him stay. I wrote letters suggesting this plan but Marcus was still evicted. Marcus and I became resigned to the fact that we would have to quickly move him.

During this period, approximately 10 months after I began working with Marcus, he became less aggressive. I could tell he felt some shame around what he had done and was also appreciative that I was advocating for him in a way that he could not. At the meeting with the manager and support team, he kept his head down and said little. I did most of the talking for him. I was playing the role of parent and he was playing the role of child. He knew this. He was verbally appreciative of my help and I can only assume he was also feeling somewhat shameful.

During this period of time, we focused on finding a place for Marcus to live. Marcus had been paying very little rent at the support hotel and would need to pay more for a place that was not as nice. We decided on a hotel located in Nob Hill, which was a much safer neighbor than where he was currently living. I set up the room and helped him collect boxes but decided to not help with the actual move.
My position allowed me flexibility in terms of the extent to which I wanted or thought I should help a client. In also could decide if I wanted to work with a client in the clinic or in the field. I decided that Marcus would have to engage with me at the clinic for a time. I made this decision for two reasons. First, I felt that Marcus needed to deal with the consequences of his actions and this meant he would have to deal with moving on his own. The second reason was that the clinic had moved to a large, clean, and welcoming building. All the case managers were given private offices to have their sessions. At this point, it became easier to meet with clients privately and more comfortably. I shifted to less outreach and more in-clinic sessions. Although this shift occurred, I continued to meet with Marcus in the field although not as frequently.

His move to the new hotel was a new beginning for both of us. I went to his new home a week after he moved in. I have had other clients at this hotel so I was familiar with the lay out and management. The manager was a homosexual man of Indian decent. He called himself Elvis and his front office/apartment was decorated with Elvis memorabilia. He was always burning incense, and there was an overflow of cloth flowers covering any blank spots on the wall of which there were few. I liked Elvis and he seemed to be kind and fair to the residents. The hotel was four stories and sometimes the tiny elevator, which I figured must have been over 100 years old, worked. The hallways and stairs were covered with mismatched carpet. I was sure they were carpet samples that were discarded from a carpet store. The walls were painted a pale yellow, or it may have just looked that way due to the residue of cigarette smoke that permeated the building. I could smell crack and speed, which smells like burning plastic, wafting out from under a door. I knocked on Marcus’ door and a woman wearing yellow rubber gloves stepped out
of her room on the same hallway and snarled at me. She would be wearing those yellow gloves every time I saw her after this initial meeting. Marcus did not open his door. I called his name and he walked out from another room followed by a woman. She was probably in her mid 40s, white, thin, and her face looked like she had been picking at it for many years. I could hear a loud shout of a male voice coming from down the hallway but I was unable to discern what he was saying. She told me not to worry. She said he was just crazy. She invited us in for a soda and I declined.

Marcus let me into his room. There was a bed with no sheets, a small desk, and a shelf attached to the wall. Once again, there was food sitting out that needed to be refrigerated. I commented as always about the food. Marcus seemed a little more receptive to my concerns than he had had in the past. He said there were mice and roaches that had been getting into the food. I gave my usual suggestions of keeping food in plastic containers and in a refrigerator, but to my surprise there was not one.

I notice that his window was covered with the sheet that belonged to the bed. Marcus reported feeling that someone was sitting outside of the window watching him. This time he did not laugh and he seemed genuinely afraid. He also presented as more depressed. This was when I learned that Marcus was a lot less aggressive and more cooperative when he was delusional and experiencing hallucinations. Although I wished he did not have these experiences, it made it a lot easier for me and I liked him a lot better.

In May, I started a harm reduction group to address substance abuse issues. I tied Marcus’ check into him coming to the group. He would meet with me for an hour, then attend group, and then get his check. I would say that this was the point when Marcus
began to really thrive. He fell into our set routine. He did not argue about money. He stopped by to chat on days he did not have appointments. He brought his frustrations to me. He discussed goals and looked forward to the future. Of course, there were set backs, such as when he accidentally burned his genitals when he knocked over a pot of boiling water, which resulted in a trip to the emergency room. Although there was no permanent damage, Marcus went through several weeks of taking too much Vicodin. There were also problems because he would come to group high on marijuana at times, which disrupted the group.

However, his drinking and marijuana smoking had decreased significantly. It was months before he would arrive again at the clinic in a state of alcoholic inebriation. His auditory voices were decreasing as well as the paranoia. Marcus also was becoming more open to discussing his mental health issues with others in the group. Another one of my clients, who experienced similar symptoms to Marcus, was in the group. Marcus seemed to benefit from discussing openly his symptoms with someone who experienced the same.

In our private sessions, I rarely addressed his mental health issues and substance dependency besides a quick check in. At the time, I focused more on building his self-esteem. Marcus was starting to look at himself as a man with mental health issues versus a mentally ill man. I wanted to focus on the positive and did not feel a strong need to discuss his symptoms or substance use.

Over the next many months, Marcus began to really excel in meeting his treatment goals. In June 2008, he entered a vocational program where he was trained in a janitorial program. I received a few reports that Marcus would occasionally appear at the
training program intoxicated, but other than those occasions, he was doing very well. He asked me to come to the graduation and I did. He was very excited about graduating and had an enormous grin on his face. He reminded me of a third grader who had just won the science fair. Marcus began his internship doing janitorial work at another mental health agency. One of his vocational goals was to work on his hygiene. Marcus was showering more, trimming his unusually long nails, and doing his laundry weekly at the clinic. It was very important for him to have clean uniforms. Marcus also obtained a Guard Card, which allowed him to work as a temporary security guard. He did this a few times at special events. Marcus’ self-esteem was soaring. I was very happy for him and was pleased with the progress he had made.

Around the winter of 2008, Marcus began asking again to receive all of his four checks at the beginning of the month. I started giving them to him. He was not very receptive to my offer to help him create a budget, however. He also did not complain at the end of the month when ran out of the money so I continued giving him all his checks at the beginning of every month. I wanted him to know that I thought he was being responsible and deserved to hold his own money.

Marcus also stopped coming to see me as much. He would say he was busy with work or out with friends and he seemed annoyed when I asked him to come to his appointments. When we did meet, he talked with excitement about his new job and the shows attending with friends. He even found another hotel and moved into it on his own. He really was embracing being a whole person versus being a mentally ill person. I decided to not push him too much about coming to the clinic. I reasoned that if he was taking his medication and presenting with minimal symptoms, then his disengaging from
treatment somewhat might actually be good for him. The question I needed to ask myself was how I would going to deal with him improving, I found myself struggling with feeling useless and not important.

In March 2009 (almost 2 years from when I first met Marcus), Marcus met a woman and began dating her. She was involved in the Reggae scene, was in her late 40s, and was Caucasian. She had several children that were older than Marcus. Marcus was thrilled and talked about their relationship for most of his sessions.

During the spring and summer of 2009, Marcus both met the love of his life and lost the love of his life. It was heartbreaking for both of us. This was Marcus’ first relationship ever. Marcus began to engage more with me. He was showing distress early in his new relationship. They argued frequently and this caused Marcus’ voices to increase and become louder. Marcus was insistent that his girlfriend not know about his mental health condition but it got harder to hide. She found his medication and started calling him crazy when they fought. Marcus began to present as increasingly depressed and under stress. We discussed the relationship between his increase of symptoms and the stress the relationship was causing him. In one session, he told me that he thought she was crazy. He told me, “It is impossible for two crazy people to be in a relationship together for a long time.” He also said, “Somebody who is not crazy would never want to be with someone like me who is crazy.” I expressed how sad I was to hear this and challenged him on this belief. I told him that it could not be true for everybody but he said, “It was.” I did not challenge him further. We just sat together.

This conversation opened up an ongoing dialogue about the stigma of mental health, specifically mental diagnoses that start with the prefix “schizo.” Marcus told me
that he told his girlfriend and others that he had bipolar disorder. I asked him why he did this even though I had a hunch as to his rationale. Marcus believed that anyone with a diagnosis that started with “schizo” was really mentally ill while those with bipolar were not as severely mentally ill. I acknowledged the stigma that went along with the diagnosis of schizophrenia or schizoaffective disorder. Marcus laughed a lot when discussing his diagnosis. I think he was avoiding going to a place of sadness by keeping the dialogue light.

While we explored this topic and he went through his first breakup, we became closer. He stopped in more frequently, and he wanted my advice regarding his relationship. I worked on building his self-esteem and being supportive of him. A few months after the breakup, he started to become angrier. He became very angry with women, especially with white women. His sessions were very focused on how cruel unstable and crazy women were. I let him rant. I let him be angry. I let him direct his anger at me. I watched him stop coming to meet me. I watched him stop coming to group. I watched him push back when I suggested he take better care of himself. I watched our relationship go from being close to being almost nonexistent. The more I pushed for closeness, the further Marcus disengaged.

Although, I am not focusing on the therapy that took place in 2010 and 2011, I have included a summary here in order to show Marcus’ progress. During 2010, Marcus’ disengagement with the clinic continued. He became more and more hostile towards me. There were some issues with his social security money. He had been collecting social security and receiving paychecks from the vocational program. The vocational program was supposed to send his paystubs to social security so that his monthly disbursement
would be adjusted. However, they did not do this and Marcus’ monthly money amount decreased in order to pay back social security. Marcus hours at work also decreased. He struggled financially. Marcus blamed me for the situation. I explained over and over again that it had not been my responsibility. Marcus would say, “You have one job and you are not even able to do that,” and “You don’t care about me. You just care about getting your check.” Marcus’ use of alcohol and marijuana increased. Marcus came to the clinic often in an irate state and meetings were held with Marcus, my supervisor, and myself regarding his behavior.

During 2011, it was decided between my supervisor, Alysia Linsenmeyer, and myself that Marcus would have his money management switched to another money management agency called Conard Services. It was also decided that Marcus would start working with another case manager as soon as the money management was switched to Conard. I met with Marcus and he agreed that it was best. It would be many months before Conard had an opening for Marcus. Marcus asked several times when he would get another case manager. He continued to be aggressive towards me but his aggression had diminished somewhat.

At this point, Marcus began to “hit bottom.” He said he was spiraling into a bad place and needed help. He had lost his janitorial job due to doing a poor job and often not showing up to work. He also had become more depressed. Marcus began to come see me more often. He would stop by the clinic and wait until I was available to meet with him. I had given away his meeting time due to his inconsistency in attending our sessions.

In May 2011, I informed Marcus that I was pregnant and he became noticeably more attached to me. He even asked me that I remain as his case manager. I told him that
we would have to discuss this when I returned from maternity leave. He was introduced
to his temporary case manager and was able to discuss with him all the topics we had
covered over the years. He even discussed our relationship, which included conflict as
well as an extreme bond. It felt good hearing Marcus’ describe our relationship to
someone else. It showed me that I meant more to him than he had let on.

I had planned to return to work after my child was born but decided instead to
resign. I decided this in the middle of July, which was only two weeks before I left on
leave. This meant that termination with my clients happened quickly. When I told Marcus
this news, he replied that he had figured that I would not be returning. Our last session
was one of satisfying closure. I did not expect this. I had expected Marcus would find a
way to push me away but this was not the case. He actually began discussing the work we
did with each other. We both expressed how important we were to each other. He
acknowledged the many difficult moments we shared and also the many good moments
we shared. Marcus also brought up our first meeting at his home, which meant a lot to
him because no case manager had come to see him at his home before. I was touched
because that meeting had meant a lot to me as well, in regards to his treatment and our
rapport building. It meant so much to me that I had made it the main focus of the
treatment within this clinical case study.

I knew I would see Marcus again. Although, he did not know this, I had moved
two blocks from where he currently lived. I had already seen him from a distance many
times and continued to see him after I resigned. I always found myself crossing the street
to avoid interacting with him but I knew that one day, I would not cross the street. I
would walk on his side of the street and give him the option to engage with me. I would
want to know what his life has been like and if there has been anything new he has experienced since we last met. I would talk with him as person who cares and not just a case manager.

**Legal and Ethical Issues**

There have been few obvious legal issues that have arisen in our work together. For the most part, I have felt comfortable about my decisions in working with Marcus. The areas is which I needed extra support from my team and supervisor were around money management and using harm reduction therapy when working with substance abuse. My team and supervisor had been very supportive in giving honest feedback.

As I mentioned above, I used harm reduction techniques when working with substance abuse in the clinic. This included running a group to using the techniques in individual sessions. Different clinicians have different lines they are willing to cross when using this therapy. Some encourage their clients to drink less while others show client’s alternative veins to shoot up when abscesses have formed on their arms. I tended to be extreme in my harm reduction methods because I believed that it is important to work with the client where their motivational level exists. I tried to meet them where they were, with as little judgment as possible.

In Marcus’s case, he smoked Cannabis daily. There are two classifications of Cannabis or Marijuana, one being Sativa, which affects the mind, the other being Indica, which lends to more of a body high. Sativa strains tend to exacerbate symptoms of psychosis, such as hallucinations and paranoia. I had suggested to Marcus that he smoke only Indica strains in order to avoid exacerbation of his psychosis. I also encouraged him
to get a medical marijuana card so that he was not smoking illegally. My supervisor was supportive of this work with Marcus around his Cannabis use while the nurse practitioner was not supportive. She encouraged him to use no Cannabis at all. I did not think it was realistic to expect such a drastic change from Marcus when Cannabis use was an integral part of his identity, and I felt that it would alienate him from treatment if we were to put this expectation on him. At that point, the nurse practitioner and I had agreed to disagree regarding this matter. Even though I felt that this was the right intervention, I still question some of my harm reduction interventions.

Money management had also been difficult for me when working with Marcus. It was difficult to be the therapist and to be a client’s money manager at the same time. Holding somebody else’s money created a lot of power dynamics. I had engaged in conflict with every client I have held money for at some point in our work together. Almost every one of my clients manipulated and/or lied to me in order to get money.

As an example, Marcus had told me that he was going to buy a microwave or go out of town for a month and I gave him extra money but then I found out that he did not buy the microwave or leave on a trip. Marcus showed no remorse when I confronted him on these issues. Legally, we could not keep money from our clients but we did use the money as incentives for various positive behaviors. For example, Marcus would receive his weekly check when he came to our scheduled sessions and picked up his medication. Marcus was aware of his rights to his money, so when he did not make his commitments, he demanded his check. I became so exhausted with our constant battles over money that I agreed to give him his money monthly. I would make sure his rent was paid and then give him the rest of the check. I was never able to change the agreement back because
Marcus threatened to go to the client’s rights board to challenge any decision that involved controlling his money.

**Outcomes**

Our treatment ended in August 2011. The outcome of our treatment together for those four years resulted in Marcus learning to look at himself as a different person, a whole person. He was able to move away from the patient role into a role that required him to be held accountable for his own happiness. Marcus was able to face his symptoms and discuss them. He was able to express and discuss his concerns around his diagnosis and the stigma that came with it. He was able to let himself hold his mental illness in relationship to his life but not make it his life. He also learned to engage in conflict and work on repairing relationships. Although he learned all these things, he still found himself returning to his old patterns and behaviors. He still struggled with his substance use, complying with his medication, keeping a job, keeping treatment appointments both for individual therapy and for groups, and managing his symptoms. He continued to need support from the clinic and returned to working with his original case manager. I realized that as Marcus grew older and he learned more about his illness, his symptoms, and his growing capacity to relate to others, the complexity of his life problems would not necessarily lessen. What gave me hope though, was that I believed that his desire for relatedness and psychological well-being would continue to increase.
CHAPTER 4

LEARNINGS

Key Concepts and Major Principles

Through the work I have done with my client and my exploration of research, I developed many learnings. Many of these learnings were ideas that I understood before, but through this process I have developed a stronger understanding of them. After exploring these learnings more carefully, I was able to look at my work with Marcus from a deeper perspective. This gave me a better understanding of our work together and, therefore, I was able to develop better interventions within his treatment.

The first learning is the importance of taking into consideration my client’s environment in order to understand his internal experience. The second learning is that African Americans, as well as other oppressed cultures, generally have a mistrust of the medical model, which had led to many untreated disorders within the population. The third learning is the importance of looking at symptoms within the context of culture. These three learnings, which evolved from the research on my client, played a large role in my work with Marcus as well as with other clients.

The first learning, which underscored the importance of analyzing client’s external environment as much as their internal process, in order to understand them in a deeper way was brought to greater light for me by Perry’s work. Perry’s focus on taking in a patient’s full surrounding as a way to understand the patient was extremely pertinent
to my job. I always enjoyed looking at my client’s environment, but in the past, I had done it mostly out of curiosity and to identify safety hazards. Perry opened my eyes more fully to the idea that the environment gives clues to the client or patients.

Perry notes:

the importance of looking not at the ‘mental context’ of psychosis but rather its relationship to the psychic life. The schizophrenic ‘disorder’ lies rather in the ego, which suffers from a constricted consciousness that has been educated out of its needed contact with the natural elements of the psychic life, both emotion and image.¹

Beck and Rector note that Perry was interested in alternative ways to work with people who have schizophrenia besides medication, locked wards, and electroshock therapy. He stressed the vital importance of remembering “that the response from a [schizophrenic]’s surroundings be in accord with the nature of the experience he is undergoing.”² Through validating clients’ psychosis, one is better able to work with their personal story in terms of their unique struggles with their environment and relationship to others. Vinogradov and Yalom note that Sullivan contributed much to the psychoanalytic perspective in relation to schizophrenia and psychosis. He, like Perry, argued “that even the most bizarre and outlandish schizophrenic productions were entirely meaningful when they are understood in the context of the individual’s interpersonal environment and social history.”³ Through this lens, I was able to gain a perspective about the importance of understanding Marcus’ environment, behavior, and history, which increased my clinical ability to treat Marcus.

The second learning involves the relationship between the African American population and mental health treatment. African Americans are much more unlikely than Caucasians to seek out treatment for mental health issues. Research shows that this is
primarily due to mistreatment by past providers, lack of African American providers, and the stigma of being perceived as “weak” when seeking out help.

The third learning relates to the principle that mental illness exists within a societal context, which in my understanding plays a large role in symptom management. In some cultures, psychotic states are viewed as mystical and religious manifestations of evil spirits or prophecy, and are addressed with spiritual methods to alleviate symptoms or spirits. These environments also provide a community for those that are suffering. These individuals are not ostracized from their community, but rather are made to feel part of their community. Research has shown that their suffering is less than those who suffer from mental illness in the Western world. Fleishman believes it is because they have families. They are not subdivided into a separate class of society; they spend their days not in alien fluorescent-lit hospital rooms but sitting on charpoys in the shade of the earthen walls of their family home, surrounded by the hubbub of joint familial life yet tactfully excused from it.4

Although there is minimal quantitative data that points to whether symptoms are a product of chemical imbalances or spiritual infestations, I had begun to look at psychosis in relationship to culture. In my work with Marcus, I started to think about how his symptoms could possibly be lessened if he existed in a different environment. I also began to think about alternative ways to work with him that would focus on creating a purpose, a support system, and building self-esteem.

**What Happened**

I initially focus on a session that I believe was emblematic of the three learnings stated above. I then proceed to a more general exploration of what happened in the course of treatment.
I had been working with Marcus for only a few weeks and he agreed that I come to his home to meet with him. His building was very clean and the upkeep was very good. There was a pond and bamboo in the courtyard where residents smoked cigarettes. I was aware that Marcus lived in a support service hotel, which meant that there were counselors and case managers available for support. I knocked on Marcus’ door and he answered it. His place was fairly large. He had a kitchenette and a large bathroom, which was wheelchair accessible and designed to accommodate individuals with physical disabilities. There was an open bottle of mayonnaise and eggs on the counter. The bathroom mirror had a sheet hanging over it. Reggae music was playing and I asked him to turn it down, which he did. I sat on a chair by a table. There was a lighter, rolling paper, loose tobacco, and small pieces of marijuana all over the table and the floor. There was a heavy scent that I was unable to identify.

Marcus sat down on a day bed opposite from the table. Another sheet hung over the window that faced the street. We discussed his physical issues and he reported that he might not need to have his eye removed. He expressed little enthusiasm around this. I also addressed the issue around him changing case managers and that I am a white female. I was aware my being white and female might be problematic to him on some level. He had reportedly had issues working with women and white people. The following is an excerpt of the conversation that took place that day.

(After a general well being check in, a long silence occurred)

Me: It must be difficult to have a new case manager. Is it?

Marcus: No, I have had many case managers.

Me: I was told that it has been difficult for you to work with white people and
females.

Marcus: Yeah.

Me: I wonder what it will be like for you to work with me since I am white and female.

Marcus: I know.

Me: I know it is early but I would like us to be able to talk about this openly while we are working together.

Marcus: (nods head)

There was a knock at the door and Marcus did not appear surprised. He stated that his mother was here to help him clean his studio. She wore very tight jeans, a tight leather coat, and a low cut top. She spoke in an overly loud voice about how much she did for her son. Marcus was quiet and did not speak except to say “okay” when I gave him his next appointment.

Over the course of treatment, we addressed many themes that were related to my learnings and our interactions during the meeting at his home. For one, we discussed the coverings on his windows and mirrors. They were related to his delusions around being watched. He mentioned people being outside of his window spying on him. Mirrors contained multiple people watching him, talking about him, and plotting against him. Marcus rarely shared information with me about his delusions. When he did share, it was when he was in less of a psychotic state. I found on my visits to his apartment that clues were present that allowed me to gauge the level of his psychosis and depression. When windows and mirrors were covered, he was in his delusional state. Sometimes, his microwave was covered, which indicated a state of marked psychosis.
When he was not in a psychotic state and when he was not in the heat of anger he was able to process his feelings in relation to my race and gender. We continued to discuss his aversion to working with females and white providers. The issue would arise perhaps in other ways when he voiced his view of my “being controlling” and my “power” in relation to him came up, especially around my holding of his money.

Marcus attended a vocational program and began work as a janitor. This event served as a transition to having many conversations about his role in the world and his struggle to be more that a mentally ill person. We discussed the stigma around his illness and how this created barriers to his sense of himself as a productive member of society.

**Imaginal Structures**

**How I Was Affected**

As I left the office to go to Marcus’, I felt excitement around going to his place. This was one of my first opportunities to do outreach at this job, as Marcus was one of my first clients at Westside. I also was excited about seeing the somewhat new support hotel, which I had heard such positive things about. I entered the courtyard and felt calm even though I had obviously had peaked the interest of some of the residents. I was impressed so far by everything I saw.

I was not afraid to enter Marcus’ room alone. Marcus did not have a violent history and my supervisor did not seem concerned by the visit. I was conscious though of the fact I rarely feel afraid in situations where I am alone with a client away from the office or when they are aggressive. I struggle with this because I believe that I have good instincts but sometimes I question my instincts, which could lead to unsafe situations.
I felt somewhat anxious by the time I reached the door and knocked on it. I was aware that Marcus did not get along with white people or females. I experienced some feelings of guilt about this. Here I was another white female social worker interfering in another person’s life. For a fleeting moment I questioned myself; I wondered how I could be of help to him and why I had chosen this profession.

I was not surprised by Marcus’ living environment. In addition to the sheet hanging on what I assumed were Marcus’ portals to alternate realities, the studio resembled that of an 18-year old who had just moved out of his parents’ home. I felt very sad at this observation because Marcus was not an 18-year old. He was a grown man. I was only one year older, yet I was so much more mature or at least in this situation I appeared to be.

I could feel Marcus’ loneliness. I could sense his fear of the outside world. I could feel how hard it was for him to do simple tasks such as come to the clinic. I had once been lonely too. When I moved here at age of 23, I knew no one and lived in a similar looking studio with my own type of mess. I knew to put mayonnaise and eggs in the fridge and there were no rolling tobacco on the table and floor but this was partially due to the fact that I could afford already rolled cigarettes. I remembered having been very sad and depressed during this time as well as paranoid about others’ motives. I was a bird that flew across country with a broken wing and could only feel the pain when I landed.

Marcus was a bird with a broken wing. I wanted to be his friend. He needed a friend just like I had needed a friend many years ago. He needed to trust somebody. I was not going to get that trust by demanding he tell me about his covered window and mirror. I was not going to get the trust by demanding he put his food away and clean his room. I
felt very unsure of what role to take at this time.

I was somewhat anxious about bringing up the race and gender conversation, but I had felt that I needed to get it out there on the table at that moment. I was surprised around how open Marcus was to discussing our differences that day and during the course of treatment. He appeared to enjoy teaching me about his culture when he was not in a psychotic or depressed state. I felt proud of myself for being able to create a container in which we could build our relationship around our differences.

When his mother came, my whole body became tense. I was shocked to see her appearance and her mannerisms. I expected her to present as Rastafarian like Marcus. I suppose this was due to me only having brief seconds to make a hypothetical guess as to who I was about to meet. I expected her to be calm, caring, and understanding. This was not what she was. She wore tight jeans, a leather jacket, and a low cut shirt. Her voice’s loud volume and the amount she talked made me want to escape. I believed that she wanted me to know how much she did for her son and she wanted him to know that too. I felt very uncomfortable for myself and for Marcus. I wondered how could this woman possibly understand what her son was going through when she was so busy playing the role of martyr? I was angry and frustrated. I felt very protective of Marcus and very aware that few people understood what he experienced as few people took the time to understand. I felt as though I were abandoning Marcus when I left, which I also thought was absurd since I hardly knew him.

As I walked back to the clinic, I felt mostly sadness. I always struggle when working with psychotic clients who are young. It is so difficult to see young people who are psychotic begin to realize that this is their life and they will not be able to have a
“normal” life. They begin to realize that they will most likely not work for long periods of time. They most likely will not marry. They most likely will not have children and if they do have children, they will most likely be taken away from them. I felt sad then for Marcus and somewhat guilty because my life has been blessed in contrast.

I also was able to recognize my own fear of becoming psychotic myself. I reasoned that it could happen; there are plenty of people who have become psychotic later in life. The other side of this fear that came up for me was, “What if I don’t become psychotic?” This fear echoed my thoughts on the way back to the office after meeting at Marcus’ apartment for the first time: “Will I always feel guilty over being ‘normal?’”

I walked quickly, taking in all the yelling, drug use, and poverty that surrounded me on a less conscious level than my thoughts about Marcus. I felt exhausted by the time I returned to the clinic. All the thoughts and emotions from the previous hour floated away as I began a session with a different client.

As treatment progressed, we discussed his psychotic delusions further. His belief that others were watching him and knew everything he thought made functioning difficult for him. I was saddened to witness his continuing struggle. I was also saddened that initially his self-esteem was so low that he truly believed that he could not do anything productive in society. I felt so proud of him when he started working, taking care of his hygiene, and decreasing his use of substances. I felt proud of myself for believing in him and pushing him to be better.

As we explored further the differences in our race, gender, and roles in our relationship, I felt closer to Marcus. When these differences played out negatively in our interactions, I was angry that these dynamics still existed. I was confused about how to
proceed at times to remedy the situation. I felt lost and helpless as I do when this theme manifests in my own personal life.

**My Imaginal Structures**

I believed that my being white and female was a deficit in my ability to provide appropriate services to Marcus. I assumed that this dynamic meant everything in the relationship versus just being part of our dynamic. Although Marcus acknowledged his difficulties with white and female individuals, he did not appear to shut me out. I wondered how important this dynamic really was to him.

I assumed that because Marcus lived alone in a messy environment that he was lonely. I identified with this due to my past experience. I felt sure that he needed a friend and not a case manager. I assumed that Marcus craved social interaction as I had years before. The truth was that just because someone is alone does not mean that they are lonely. Not everyone bases their existence on the relationships that they have in their lives. That was my experience and may not have been his. Marcus at that moment in time was very paranoid and being alone might have been what he craved and needed.

I assumed that Marcus’ mother would be like Marcus. I assumed a person learns, grows, and becomes like their parents. I assumed one’s values and beliefs came from both parents. I also assumed that one was born Rastafarian and did not necessary choose to be Rastafarian. I did not assume that there would such a marked difference in their personalities. I also assumed his mother would display a more nurturing attitude and want to engage with me over how to treat her son’s symptoms. However, not once in four years did she meet with me or discuss her son’s treatment with me.
The Client’s Imaginal Structures

During the meeting at his home, Marcus did not speak any statements that I felt were indicative of imaginal structures. He spoke concretely when asked questions. He spoke about his physical issues and responded minimally to my questions regarding our differences. I could only make an assumption that Marcus believed that I would present as an authority figure because of my role and my color. I imagined that Marcus would assume that I would be verbally inquisitive of his window and mirror coverings and admonish him about his food that was left out because that is what case managers do.

During our treatment, I gained insight into Marcus’ structure that he was not capable of working or having an identity other than just a client or patient, a person with a mental illness. Another one of Marcus’ imaginal structures was that white people did not have mental illnesses. Marcus also believed that “crazy people” could not engage in romantic relationships. We addressed many of these constructs in our sessions.

New Learnings about My Imaginal Structures

Most of these imaginal structures came from an initial place of thought, and after thinking further, I realized that they were not truths. Although I rationally could explain away these imaginal structures, I realized that there must be something in my unconscious that made me think these untruths while in the moment. Some of the following imaginal structures are related to my learnings, while others are in addition to the learnings discussed above.

The structure, “I am white and female so how could I help and be understanding of Marcus and his situation,” was unusual in some ways. As far as being white and
female, I knew that a leopard could not change his spots. I knew that this is who I am. I knew the interventions to use when these issues arise. I have always been very comfortable discussing this topic with individuals of other races and genders. I have always thought that the dialogue around race and gender can be powerful and transformative for both my clients and myself, yet I still had feelings of guilt. The concept “white guilt” is powerful and has surfaced frequently in my work along with having more money, more family support, and just an easier time in this world than most. I checked those feelings quickly but I knew they were still there. If I learned anything new around this, it was that these feelings would continue in spite of my conscious objection to them. I knew that they would resurface in my work and in my personal life. I realized that I have always felt the need to give away or down play my power and authority to those who are not white due to the guilt I feel. I have learned that there is a lot of work to be done in this area and that change does not occur overnight.

Another structure that I had was, “Marcus is lonely because he is alone.” I realized subsequently to having this thought that I over identified with my client over his being alone. I wanted to display empathy towards him and found myself accessing this through my experiences. I did not take the time to look at the big picture. He had schizoaffective disorder, which involves being paranoid, which leads to isolation. He most likely wanted to be alone, which was when he felt the safest. Being alone and in his room allowed for some alleviation of his symptoms. I did not think about this until writing the progress note. I wrote a mental status exam and then the impact of his diagnosis on his environment became more apparent.
Much of the time, Marcus did not present in ways that my other psychotic clients had; he appeared less affected by his symptoms. He did not always present as psychotic or disabled. I found that over the years of treatment, I had to constantly remind myself that he experienced psychosis. I needed to look for clues in his environment to identify his level of psychosis because he did not always present his symptoms in an obvious manner.

Another of my imaginal structures was, “People are like their parents.” I found out later that I was somewhat right in this imaginal structure; Marcus had in fact picked up his Rastafarian ways from his father. Although I have known many people to hold their parents’ beliefs and values, I have also known many do not have the same beliefs and values. For example, my parents and I do not share the same ideas of many things. So I had to wonder why I jumped to this conclusion? Did I hope that Marcus had someone in his life that understood him in all ways and was there for him? Was it easier for me to put his mother in a box so that I would not be anxious about who was going to walk through that door? Did I wish that my parents understood me more and was I projecting this wish onto Marcus?

The fourth imaginal structure activated during this meeting was, “Mothers are nurturing and understanding.” I wanted this to be true for Marcus. I wanted him to have a mother who understood him. I wanted him to have a place where he could feel safe. I also recognized later that Marcus’ mother was being nurturing in her own way by coming to his home to help him clean. We all have varying capacities to nurture and understand others and unique ways to express them, and this fact was important for me to recognize more fully when working with Marcus and has continued to be important to maintaining
satisfying relationships in my personal life.

I learned something very valuable from the last two imaginal structures. I learned that some of my imaginal structures were based on what I wished to be and not on my clients’ or others’ actual reality. I have learned to be more aware of my structures and more open to what is occurring in the moment, but I continue to recognize the difficulty of this process. By slowing down the process and looking at my imaginal structures along with Marcus’ imaginal structures, I was better able to understand our interactions. I was able to realize how important these interactions were to the work we did together.

**Primary Myth**

Many myths and stories, including the ones presented in my literature review, demonstrate psychotic thoughts and behavior. For the purpose of a deeper exploration, I have chosen to focus this section on the story of Alice in Wonderland. Not only does this story explore the psychotic thoughts, behaviors, and perspectives of an alternative reality, it explores the journey of Alice, an explorer trying to make sense of her surroundings. When working with Marcus, I found myself identifying with Alice and her journey into Wonderland. First of all, I recognized that I was different from him and that I could not always trust my perceptions of him. I learned to pay closer attention to his environment to better understand him. I learned that his level of “craziness” did not just change in regards to his social context and by how he was treated by others. The rules of reality were different.

Along with my identification with Alice, I identified Marcus’ psychotic state with Alice’s journey. He experienced a psychosis that at times was very much like a journey in
which he had minimal control. He was frightened when his psychotic states began, but he would become so engaged in his delusion that his fear turned to a fight to survive. When he exited his psychotic state it was as thought he were Alice exiting the rabbit hole. He would let the journey soak in and then wanted to share his experience with me.

When I identified with Alice, I looked at Marcus as identifying with the many characters in the story. All these characters presented with various characteristics, moods, and affects. All of them had a story to tell and many of them wanted to share their story from what I believe was a deep desire to find connection and be understood.

I reviewed the story chapter by chapter, character by character, interaction by interaction in the hope of shedding light on how these various stories demonstrate various symptoms, which include psychosis and depression. I reviewed these chapters from the perspective of my own identification with Alice in her quest to understand the symptomology of Wonderland.

In the first chapter, “Down the Rabbit Hole,” Alice entered her journey. She showed little fear but did show anxiety over how she would interact with others at the end of the hole. When thinking about a hypothetical encounter, she stated to herself “And what an ignorant little girl she’ll think me for asking! No, it’ll never do to ask: perhaps I shall see it written up somewhere.” 5 Like Alice, I was also hesitant to ask questions at times for fear of seeming like ‘an ignorant little girl.” I have learned to observe first in hopes of finding the answer before putting myself in a position of possible ridicule.

Alice then came “upon a low curtain she had not noticed before, and behind it was a little door about fifteen inches high: she tried the little golden key into the lock, and to her great delight it fitted!” 6 In Marcus’ home, I too, had come upon curtains that hid
alternative realities like Wonderland. I too wanted to find the key that fit and like Alice who went through many changes or transformations, I too had to transform myself in order to build trust with Marcus and enter into his world.

As I explored further the landscape of Wonderland through reading Lewis Carroll’s amazing story, I found myself feeling the disconnection and confusion that exists in Wonderland. I spent a lot of time in Alice’s shoes trying to understand in order to reduce the feelings of confusion and being ungrounded that I had. I realized that understanding came when I/Alice stopped trying to understand. Alice asked a lot of questions as I had a tendency to do. This habit may have stemmed from a realization that many people enjoy being asked questions and telling their story. The March Hare and The Mad Hatter felt compelled to tell why they must have tea continually. Then there was the mouse that said, “Let us get to shore, and then I’ll tell you my history, and you’ll understand why I hate cats and dogs.” This was in response to Alice stumbling through the topic of cats and dogs. I believe Alice was trying to build rapport with the mouse but instead was making the mouse feel anxious and paranoid. Like Alice, I have had moments of wanting to make a connection and in the process have brought topics to the surface that have created more anxiety for Marcus.

Alice showed her impatience at times as can be seen in her interaction with the Mock Turtle. She was brought to the Mock Turtle by the Gryphon at the instruction of the Queen for Alice to listen to his history. The Mock Turtle was “in the distance, sitting sad and lonely on a little ledge of rock, and, as they came nearer, Alice could hear him sighing as if his heart would break. She pitied him deeply. ‘What is his sorrow?’ she asked the Gryphon.” The Mock Turtle was very driven to tell his story, which is
demonstrated by the following forceful statement: “Sit down, both of you, and don’t speak a word till I’ve finished.” 9 The Mock Turtle took a long time to tell his story and became very infuriated when Alice asked questions. Her impatience made it difficult for her to interact positively with the Mock Turtle. I too have found myself frustrated by the way Marcus told his story at time. My impatience had caused problems in building positive rapport and I had to practice patience around getting to know Marcus’ story. I worked to let his story unfold at his pace. These stories gave Alice clues as to the characters’ histories as well as to the intensity of what could be called their psychotic experience. Alice was desperate to understand, which led her to be overly inquisitive and at times even off-putting with her remarks. Her drive to understand at times infuriated the characters. I also have noticed that too much questioning or challenging caused Marcus to become frustrated and more withdrawn.

In chapter five, “Advice from a Caterpillar,” I could not help but compare Alice and the Caterpillars interactions with those of a therapist/client or clinician/supervisor. Alice met the Caterpillar who asked her, “Who are you?” 10 Alice replied, “I-I hardly know, Sir, just at present – at least I know who I was when I got up this morning, but I think I must have been changed several times since then.” 11 She had lost her ability to know herself due to the strange interactions she had had that morning. The Caterpillar appeared to be working with Alice to get to the root of her confusion. Alice realized that she had changed but needed the guidance of the Caterpillar to be okay with the change and be able to be more active in future changes. The Caterpillar helped her to learn how to change her size. I, like, Alice have had teachers, mentors, supervisors, and therapists in my journey who challenged me, advised me, and supported me in making decisions.
Without the “caterpillars” of my journey, I might have had minimal transformation and would have been unable to explore further in ”Wonderland.”

In chapter 7, “A Mad-Tea Party,” presents what it truly was like for Alice or myself or Marcus to walk into madness and only understand the madness by experiencing it and listening. By bringing in the Mad Hatter, Lewis Carroll brought into the story a character that held a real place in a non-fantastical world. A *hatter* has a reputation of being “mad.” This was because “Mercury used to be used in the making of hats. This was known to have affected the nervous systems of hatters, causing them to tremble and appear insane.”  

Alice’s encounter with The Hatter, The Dormouse, and The March Hare proved to be an exhausting experience for her. They were confrontational and left her confused.

Alice ended up leaving hastily and stated, “At any rate, I’ll never go there again.” Like Alice, I was able to leave the situation when it became too confrontational or unhealthy. Marcus unfortunately was not able to leave his situation of psychosis and chaos. His psychosis could be relieved with medication but many times his psychosis created a barrier to him taking his medication. The voices would tell him that his medication was poisonous; however, eventually, Marcus’ psychosis would subside on its own and he would begin taking medication. Unfortunately, Marcus did not have control of when this would happen. He was at the mercy of his symptoms. Through this story, I learned to have more compassion for Marcus and how he must have felt trapped when he was in a psychotic state.

Through working with this story, I was able to really feel into my experience of working with Marcus and many of my other psychotic clients. I have shared in Alice’s
confusion, feelings of being lost, awe, and frustration around wanting to solve problems. I have experienced what it is like to feel as though I myself were psychotic and briefly to not know whether I was experiencing reality or not. Marcus’ reality could seem pretty realistic for brief moments and this left me feeling ungrounded at times. If anything, Alice’s story is most similar to mine in that I struggled to be a part of Marcus’ psychosis while wanting to be helpful and get to the root of it all. In the process, Alice had learned a lot about herself, as I felt I had learned a great deal about myself and Marcus.

Alice’s story reflected Marcus’ journey in that he was confronted by the many symptoms that exist in Wonderland along with the confusion that comes with them. He eventually escaped the rabbit hole but only because the story was done with him and not because he was done with the story.

**Personal and Professional Development**

As the years have passed, I have had time to work on these imaginal structures that presented themselves that day. I have found that this work addressed many of my own personal issues as well as professional ones. I have found that this will be a never-ending journey and that my work in these areas will be ongoing. I have realized that there is no final answer, just a constant awareness that there is work to be done.

As far as working with the African American culture, I have attended many cultural competency trainings, read books on the issue, and addressed dynamics in supervision and also in therapy. I found myself addressing feelings of guilt, which appeared to be masking anger. I continue to work on this anger around this dynamic, which continues to occur and I pay attention to how this dynamic plays out in my
personal story.

I have learned to not jump to conclusions about how my clients experience life, especially when these conclusions are based on my own experiences. I have come to realize that yes, we are all human but we are also different with different feelings about different things. While working with Marcus, I was still learning how to pick up clues about my client as I was present in the room with him. Working with Marcus helped me learn the importance of holding generalizations loosely, while remembering that each client is an individual person.

As a child, I did not always have the emotional and physical nurturance needed to grow, and this may be why my personal and professional style was not more nurturing than it was at the time. I convinced myself that I did not need to be nurtured. At times, I projected this inclination onto my clients, believing that they did not want to be nurtured. I began to realize that I was the one having difficulty providing a nurturing emotional environment. I realized that part of the work was to teach my clients and myself that being taken care of emotionally can be painful but also very healing.

I have also learned to be more open-minded about the causes of psychosis. I have become very interested in how the symptoms relate to the social context. I have looked more closely at alternative ways and settings to treat psychosis. I have also learned the ways in which discussing with my clients how other cultures view and work with mental illness was very healing for them.

I have continued to grow and hope that I do not stop growing and that I continue to come across and meet new challenges. I have continued to set the intention to be open to experiences and to challenge the imaginal structures that limit my experience. I have
learned that to do this requires slowing down and looking at what is going on around me so that I can fully understand who I am and who I am with at that moment.

**Applying Imaginal Approaches to Psychotherapy**

As with all my clients, I did not start using imaginal approaches in the early meetings with Marcus. In the beginning, I usually did not use any specific approaches besides observing and building rapport. Although techniques from imaginal processes were not initially used, I used imaginal psychology in my observations. I made mental notes about images, imaginal structures, and potential imaginal interventions that could be beneficial in the future.

As well as observing, I worked to recognize the soul that lies in each client and the struggles it undergoes. I did this in order to establish connection with my clients although it may not have been noticeable to them or an outside observer. I have found that as my studies have increased, I used these approaches, concepts, and principles more and more and sometimes without realizing it.

At times it was difficult to bring in imaginal psychology or imaginal process (Meridian’s approach to transformative learning) into my treatment with Marcus. The nature of my position was responsible for this difficulty. Clinical case management can be confusing at times. I was not always sitting in a room having a “therapy session” although my interventions were meant to be therapeutic. Many interventions were geared towards having basic needs met. For example, Marcus lost his housing and I assisted him in getting new housing. I did not focus on anything but this task when the need occurred.
My goal was to keep Marcus safe. This included physical, emotional, and psychical safety. I recognized that this was not always possible but my goal was to try my best.

Part of ensuring Marcus’ safety was understanding his feelings and reflecting these feelings back to him. He had difficulty expressing his feelings at times so I would need to look at the images that existed in his environment or that were expressed verbally. I would closely observe Marcus when he covered his windows and mirrors. I knew these coverings were to protect him from the unsafe world that existed behind them. This world was part of his reality and I honored this experience as true for him.

I recognized that he had found ways to cope. I always felt that these windows and mirrors represented more than just portals to his unsafe realities. Perhaps they represented the “fence” that one could fall quickly off into madness or maybe they represent Marcus’ shadow or unconscious evil.

He would mention a man outside his window that sat and watched him. He said the man would sit on the windowsill and taunt him. These images of being watched have surfaced frequently in my work with Marcus and other clients. I have struggled to understand what is behind these images and delusions and continue to wonder why so many people who experience psychosis feel they are having their privacy invaded. Due to these delusions, I have realized that I need to be very careful about how much I invade. I have realized that safety for many means having control of their own lives and physical environments without interference.

When Marcus had been without psychosis for a time, I began to use approaches or interventions from imaginal process. Of course, there were necessarily some variations to accommodate his needs. I put a great deal of effort into encouraging Marcus to develop
his whole self. I did this work by encouraging him to identify various parts of himself, his values, his beliefs, and his interests. For example, he worked on an art project that specifically addressed his Rastafarian roots. He made a flag and drew Rastafarian people doing different activities. This opened up a discussion of what it meant to be Rastafarian. We explored this further by acknowledging a Rastafarian subjectivity, which he showed pride about. (By subjectivity, I am referring to a term from Imaginal Process, which is seen as an aspect of one’s self that one begins to explore and acknowledge as being a significant part of one’s self.) I encouraged him to further identify what this subjectivity meant to him. He also developed his working subjectivity, which encouraged him to feel that he was capable of contributing to society. He developed his romantic subjectivity through having a relationship for the first time. I encouraged Marcus to sit with these different subjectivities in his therapy and to acknowledge how it feels to be a Rastafarian, a worker, and a boyfriend.

We also acknowledged that there was a psychotic subjectivity, or a “psychotic position.” Marcus talked about his psychotic subjectivity as if he were another. He laughed at his psychotic subjectivity and called himself stupid. He became depressed when he left his psychotic subjectivity or the “psychotic position.” We discussed this depression and his feeling a lack of control when this subjectivity made itself present. It was very difficult for him to be reflexive when he was in a psychotic state. We did exercises that involved him talking to his psychotic subjectivity from the subject position, although we did not call it the subject position. Marcus had shown anger towards his psychotic position, which usually faded quickly. He had difficulty participating in these exercise at times, but when he participated fully, those moments were very touching.
He usually started to laugh and said he thought it was strange. I laughed also because it was a bit strange. This left us laughing together, which was the best learning in this process. Humor brings a level of closeness, which is hard to achieve with even some of the best clinical interventions.
CHAPTER 5

REFLECTIONS CHAPTER

Personal Development and Transformation

I have learned much about myself through the process of writing this clinical case study. I would normally move through the clinical experience with little to no thought to the interactions that occurred. Primarily, this was due to a large caseload, and the experience I have garnered over the years, which has enabled me to conduct interventions without having to do a lot of processing them. The exception would be if I were affected in some very emotional way; I knew that being affected powerfully might be damaging to the treatment of the client. These reactions are sometimes difficult to recognize and even more difficult to reflect upon.

My experience with Marcus did not initially cause me to do much reflection but once I did I found that there really was much that lay under the surface of our relationship. Also, the writing of this clinical case study gave me not only a personal context to work from but also a worldly context to work from. This has left me feeling more supported in my work. From having engaged with the work on this level, I feel less alone and less confused. This has led me to be more effective in my work and have more confidence in my interventions both professionally and personally.

An important transformation that has occurred is that I have learned to be a detective while also being a supportive force. I have learned the importance of one’s
environment, dress, and mannerisms in relation to one’s inner process. In the past, I would not have looked at or analyzed anything except the person’s words, but now I focus some of my attention on these other aspects of the person.

I have always been curious by nature and this curiosity is peaked when someone does not verbally share information with me. I have begun to understand that what is not said sometimes says even more. I have begun to realize that choosing when to comment and when not to comment on a client’s environment or behavior plays a huge part in being an effective therapist. I have been much more able to “hold my tongue” and to check my high level of curiosity than I was at the beginning of this process and I have begun to understand the importance of this ability in building trust.

I have started to work on why this is so hard for me. I have recognized that I have a desire to know everything, and when I do not, I feel ungrounded, unsettled, and less confident in where the relationship stands. This has been one reason I have tended to avoid people in my personal life who hold back personal information. They tend to make me nervous and anxious. I saw the need to explore this characteristic of mine even further and to look at how my feelings around people who withhold information have shown up in my work with clients and in my personal relationships.

As I have explored what is not spoken, I have gained a keener ability to take in external clues through going to clients’ homes and seeing how they interact in the community. I know that I will not always work in a job that will allow me to see a client’s home or neighborhood but this experience with Marcus has allowed me to understand that I may miss certain pieces that might be beneficial to explore when
working with clients in the future where I may not be able to do outreaches. I will keep in
mind that there is so much more than what sits in the therapy room.

More transformation has occurred in my continual journey to understand my
place as a white, female therapist. I have become more aware of how heavy this weighs
on me in the context of my professional as well as my personal life. My work with
Marcus pushed the boundaries that caused my “white guilt” to be activated. This pushing
made me confront within myself the parts of me that struggle to accept who I am.
Although on some level I understood that I was not responsible for what happened a
hundred years ago and that African Americans have very good reasons to be mistrustful
of therapy, I must acknowledge that I hold some of the responsibility for these truths. I
have also learned that I still hold anger about being confronted with issues involving
racial differences in relationship to power and authority.

I found that I was faced with this to a great degree by my work. My clients were
mostly open to discussing their feelings of inferiority and much of the time these were
addressed in terms of racial differences. However, I have to admit having been angry that
these dynamics exist and angry when negative feelings about the white race have been
directed at me. The transformation that has occurred around this is that I have started to
work through this anger and guilt, which are so intertwined. As with so many thing in my
life that have made me angry, I eventually shifted to a place of sadness.

This sadness has allowed me to become more accepting of the dynamics involved
in the complexities of race relations. I have been saddened by what a big, negative part
race has played in the world. I have been saddened that there have been so many areas in
life that continue to be affected negatively by racial differences, such as jobs, friendships,
romantic relationships, schools systems and so much more. I have become aware that racial differences are celebrated but have found it hard to acknowledge this at times when so much negativity exists. My transformation has been about learning to hold many elements around racial differences, such as anger, sadness, guilt, self-forgiveness, forgiveness towards others, my generalizations and stereotypes about others, and my desire to change my relationship with this dynamic. As with any transformation, I have learned that I have so much more work to do in this area.

I have also transformed my perspective of mentally ill individuals. This transformation has entailed perceiving mentally ill individuals as having mental impairments. Our society often has dictated the labels we put on others. I began to question these labels. I have always felt uncomfortable diagnosing people with various disorders. I have understood diagnosis as helpful for treatment planning and medication management but have come to realize the extent to which it could limit oneself to thinking of oneself in terms of a diagnosis, as it did for Marcus. Through reviewing other cultures and their ideas and responses to those with mental illness, I learned that there was more to mental illness than the DSM-TR-IV described. I learned that symptoms could be a product of one’s environment. I even began to question whether psychotic symptoms might not be a product of a connection with an alternative spiritual reality that some of us may not be blessed to experience.

Personally, I have experienced mood states that involved high energy, increased creativity, epiphanies, and feelings of increased connection to alternative existences. The DSM-TR-IV refers to this as hypomania and medication takes care to stifle this mood but I have often wondered, what if, in fact, this mood was not called a disorder and was
allowed to exist without judgment? Through examining these ideas, I have started to think about how much our society dictates what is normal and what is not. I have become curious to know what would occur if one was to put a person with severe mania or psychosis in nature without structure of society, whether they would have negative experiences. This experience has allowed me to question further the efficacy of treatment in the United States and other Western cultures. As I have taken in and processed these ideas, I have begun to transform the work I see myself doing in the future.

My own relationship with psychosis has transformed. I used to take a very “me and them” approach in my work. I may have done this because my ego boundaries were less developed and I felt safer. A lot has happened since the beginning of this process. I have dealt with learning to manage my own depression, hypomania, and anxiety. I have had a coworker who was a close friend exhibit psychotic symptoms that led her to leave her job and seek inpatient and then outpatient treatment. I also witnessed a friend suffer many psychotic episodes, most likely due to his substance use. I have talked to therapists who described their experiences around loss of ego boundaries that led them to experience psychotic-like symptoms. I have worked with clients who have functioned as productive members of society until they had a psychotic break in their 30s and 40s and I began to ruminate on the question, “Could this happen to me?”

In the last few months of working with Marcus, I began to experience moments of questioning about the extent to which my experience is reality. During the final phase of my work with Marcus, first my grandmother and then a close friend passed away. I found myself more focused on other worlds and other existences. I found myself ungrounded in terms of knowing for sure what was considered reality. I also immersed myself in the
story of Alice in Wonderland and fell down the proverbial rabbit hole. As I did so, I began to feel that I was more confused than my clients. I felt myself entering further into their psychotic states and allowing them to be my guide, my storyteller, and my teacher. By allowing this, it was harder for me to disengage after sessions. It was more difficult for me to enter into the “real world.” I have been greatly curious as to how this had happened and where my desire was coming from to be elsewhere than my given reality. I am sure the combination of personal exploration around death, the stress of terminating with clients, being on the precipice of motherhood, and throwing myself into this clinical case study played a large part.

This learning experience has taught me to take the time to review my interactions with clients in slow motion. It has taught me to reflect on all aspects of a session, negative and positive. Most of all, this process has taught me to be able to look at the pieces of myself that feel awkward, uncomfortable, and undeveloped. I have gained much insight into schizoaffective disorder, African American culture in relation to mental illness, and my own imaginal structures that have created barriers in building relationships with my clients. This process has not only opened the door of self-exploration further, it has created a container in which to do this work.

**Impact of the Learnings on My Understanding of the Topic**

The focus of this study was schizoaffective disorder with a strong focus on the African American culture. Through exploring research on this topic, my study began to take on a life of its own. My focus expanded to a better understanding of mental illness in general within the African American community, and the reasons around the lack of
treatment being sought by this community. I also expanded my understanding of psychosis within different cultures and alternative treatment approaches. My exploration around the importance of environmental clues has also led to a better understanding of my topic.

I have worked with many African American clients who presented as withdrawn and cautious when sharing their internal experiences. I have always understood that the great mistrust of Caucasians that exists for many African Americans. It was not that long ago that slavery and segregation existed. The research showed that this mistrust was not necessarily addressed towards Caucasian providers but providers in general. Research further showed that there are numerous ways that African Americans have been wronged in the medical and psychiatric community. They have been given inappropriate diagnoses, experimented on, and have been made to feel inferior. Their fears have been passed down through generations and unfortunately stem from events that are not many decades old. A better understanding of this history has given me a better understanding of my subject client’s paranoia and other Africa American individuals who suffer from mental illness.

Through my intensive research process, I found myself gravitating away from cognitive and biological models of psychosis and mood disorders. Ellis and Beck gave me important ideas that were necessary to gaining an understanding of my client and the nature of mental illness, primarily schizoaffective disorder, but these concepts and principles did minimal good in helping me look at my client’s and my own personal process in the treatment. These concepts and principles did not address the bigger picture that I found to be pertinent and helpful in providing treatment to Marcus.
I found myself drawn to looking more closely at the “container” as well as the “subject” that lived in the container. I had begun to question how much of my client’s symptomology stemmed from his cultural environment. The exploration of this topic had led to a much greater question about how we as mental health practitioners approach these individuals and their sufferin.

As my topic has shifted due to my interest in how the container affects the subject, my topic had also grown to include how the subjects’ internal process affects their environment. My learnings, derived from ideas of Perry, have led me to place great importance on reading environmental clues in order to understand the client. Without these external clues, the full understanding of our clients’ suffering is lost.

My research on the topic, my formulation of the learnings based on this research, and my personal experience has led me to look further than the initial topic that existed when I began this process. I suppose like most things, expansion of ideas occurs when one spends a lot of time sitting with those ideas.

**Mythic Implications of the Learnings**

Throughout my work with Marcus, there were times when the stories, myths, and archetypes were very present. As discussed in the Learnings chapter, the story of Alice and her adventures in Wonderland were never far from my work with Marcus. Through a strong analysis of this story along with other myths about being lost in madness, I have gained more knowledge about what my subject-client, Marcus, experienced. There was room to discuss this in our sessions. It appeared to be beneficial for Marcus to have someone reflect back to him his experience and the lack of control he must feel.
Significance of the Learnings

The learnings that have been born from this process have created a desire in myself to further explore and to utilize this information in creating my own approach to treating those that suffer with psychosis and mood disorders. Research has been done on ideas and principles that resemble my learnings, although my learnings relate to my personal process. As with any principles, further development of these approaches, principles, and concepts can still occur.

I have found that my learnings about treatment of African American mental health clients are vital to staying aware of this information to better understand the treatment dynamic that exists. I will continue to develop this learning within my own practice.

My true interest has continued to lie in examining the environment and subject. I have learned primarily from Perry’s work that the environment leads to a better understanding of the subject and I learned from cultural differences in treatment that the environment leads to altered levels of symptom severity. These two learnings may lead to a further learning that could benefit those who suffer with schizoaffective disorder.

While doing therapy, therapists, including myself, have a tendency to delve into the relationship between the client and themselves as somewhat of a reflection of the client’s suffering and ability to engage in the world. This examination of transference and countertransference is helpful in many ways, but it does not encompass all elements that need to be addressed in order to treat the client.

My learnings provided a backdrop in which to work in a way that encouraged me, as a therapist, to engage in more of a detective approach. I found that Marcus and other
clients who suffer with psychotic symptoms were less likely to engage in relations with me but more with their environment. The learnings around environment encouraged me to work to reflect this principle, which led to a better understanding of what Marcus experienced.

The learnings gained around the context of the environment and the effects of the environment on the level of symptomology supported my decision to engage with Marcus in the community as well as at his home and at the clinic. It was apparent that his symptoms changed in severity in relation to his environment. In crowded places, he appeared more internally preoccupied, which was an indicator of increased auditory and visual hallucinations. I noticed others looking at him in a questioning ways at times based on his strange and erratic behavior. I noticed that Marcus was on some level aware of this recognition. He discussed his heightened stress levels in these situations. I wondered at times what his symptoms would look like if we were not in a crowded city. Would they be less?

**The Application of Imaginal Psychology to Psychotherapy**

I believe that the ideas of imaginal psychology presented themselves throughout my work and through the research that I chose to focus on in relation to my learnings and treatment of Marcus.

In addition, my treatment of Marcus reflected imaginal approaches, especially through our work involving identification of his subjectivities. The idea of this work was to allow Marcus to engage with other parts of himself and to challenge his mentally ill subjectivity, which carried so much shame for him. This shame held him back for a very
long time in developing as a more whole person. This engagement with his more positive selves led to more confidence and better self-care.

The exploration of images in Marcus’ psychotic experience had also been most helpful in engaging with him. My observations and then the processing of images such as covered windows and mirrors allowed me to understand the paranoia that Marcus experienced. This understanding has allowed for better treatment and care.

I foresee imaginal psychology playing a large part in work with people who experience psychosis. Imaginal psychology supports the idea of altered realities such as dream states, which would lead one to believe it supports the idea of reflecting psychotic clients’ experiences as their true reality.

**Bridging Imaginal Psychology**

Imaginal psychology plays a great role in creating a container of better understanding in order to support Marcus in his process. The understanding of his culture, personal myth, archetypical journey, images, and story laid a foundation, which supports treatment. This foundation is also present in myself. My extensive work with the imaginal process gave me a better understanding of myself, which allowed me to have a fuller understanding around the interactions that occurred between Marcus and myself.

Most importantly, the work around soul and the afflictions that cause such unhappiness played a large role in my work with Marcus and those that suffer in such a way. Their souls’ experience long stretches of having no rest. They view their soul as evil, demonic, and as an enemy versus as a victim of pain and suffering. I used these
ideas in order to access my compassion and present an over-arching goal of providing support in the hopes of lessening the soul’s suffering.

I used principles and practices from Imaginal Process when working through my countertransference towards clients and other barriers that occurred when working to provide appropriate treatment. For example, I worked with my various subjectivities that were alive in regards to racial differences between my client and myself. There was my angry subjectivity, my sad subjectivity, my guilty subjectivity, and my accepting subjectivity. I utilized forms such as the four-plus to explore my ability to be reflexive which means to move from subjectivity to subjectivity.¹ This allowed me to recognize which “self” was showing her face in a given situation, which allowed me to work more appropriately with myself and my client’s issues.

Areas for Future Research

I would like to see or, even better, be a part of future research that lends itself to creating treatment approaches to support individuals who experience schizoaffective disorder. I would like to participate in the future research by actually creating or supporting new treatment modalities. The research would emerge from the observation of new treatment ideas and would aid in developing the treatment modalities even further.

I would like to see more approaches that have a primary focus on developing one’s capabilities versus focusing on the hindering symptoms. Other cultures appear to follow this idea more than the culture in the United States and the outcomes have shown to be effective. Through providing jobs, projects, and classes to those who suffer with psychosis and other symptoms, we may allow them the capacity to view themselves as
more than merely a person with a mental illness. Research is needed on the extent to which encouraging those with mental illness to share about their interests, ethnic backgrounds, religion, values, and beliefs increases their self-esteem.

There is also a need for more research of the environment’s effects on those with mental illness. If the research shows a marked difference in symptom levels, which point to higher levels of symptoms in the Western world, there might be more of a move to provide treatment environments that do not operate out of clinics and hospitals. These environments would ideally support the development of one’s purpose versus symptom management through medication and coping skills.

Although my interest lies in clinical treatment, I believe that much useful research could come from examining the outcomes of treatment approaches that address a focus on the whole individual, life purpose, and creation of a healing environment or container.

I was able to treat Marcus by helping him identify his various subjectivities, but have continued to remain very curious about what his symptomology would look like had he existed in a different culture or time. If he lived in a time with no alcohol and drugs, would he have presented with fewer symptoms? If he were part of a tribe in Africa, would he have been revered or looked at as evil? There is no way to know but I do believe that we can create environments that may lead to more effective approaches for those suffering from psychosis. Research could then provide answers to some of these “what if” questions.

I would like to create an environment far from the city, drugs, alcohol, constant loud noises, and external stressors. This environment would be a farm where people who suffer from mental illness would have jobs and a sense of purpose. This environment
would provide clinical and medical support for clients when and if they decompensate. This environment would provide a container that facilitates a sense of safety as best as possible. This environment would encourage people with mental illness to bring forward their knowledge and interests to teach each other. This farm would also be an excellent place for research to occur regarding symptomology in relation to its container. Creating an environment that facilitates the lessening of suffering does not guarantee this outcome will occur, but it would provide an opportunity for further research on symptomology in the context of its environment.
APPENDIX
APPENDIX 1

INFORMED CONSENT FORM

To [name of client subject]:

You are invited to be a subject of a Clinical Case Study I am writing on [general topic area]. The study’s purpose is to better understand. [briefly explain the general topic area in terms understandable to lay persons].

For the protection of your privacy, all of my notes will be kept confidential and your identity will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to [name the population the client represents, such as single mothers, recovering alcoholics, etc., if relevant] and may benefit the understanding of [name the general topic area you are researching].

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing that you are the subject of the study could affect you in ways which could potentially distract you from your primary focus in the therapy. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your role as the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Academic Services Coordinator at Meridian University, 47 Sixth Street, Petaluma, CA 94952, telephone: (707) 765-1836.

I, _________________________, understand and consent to be the subject of, or to be referred to in, the Clinical Case Study written by [your name], on the topic of _________________________. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by [your name]. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of the Informed Consent form. My participation in this study is entirely voluntary.

I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not
limited to, information which may be considered private or confidential. I understand that [your name] will not disclose my name or the names of any persons involved with me, in this Clinical Case Study.

I hereby unconditionally forever release [your name] and the Meridian University (and all of its trustees, officers, employees, agents, faculty, successors, and assigns) from any and all claims, demands, and legal causes of action whether known or unknown, arising out of the mention, use, and disclosure of my clinical case history, and all information concerning me including, but not limited to, information which may be considered private or confidential. The Meridian University assumes no responsibility for any psychological injury that may result from this study.

The terms and provisions of this consent shall be binding upon my heirs, representatives, successors, and assigns. The terms and provisions of this consent shall be construed and interpreted pursuant to the laws of the State of California.

Signed this ________________, 20__, at ___________________.

Day                           Month                     Year                         City                            State

By:_____________________________________________________________________

Client’s signature

Print client’s name legibly and clearly on this line


4. Ibid.


Chapter 2

2. Ibid., 60.
4. Ibid.
5. Ibid.
8. Ibid., 63.
11. Ibid., 18.
13. Ibid.


20. Ibid.

21. Ibid., 7.

22. Ibid.


24. Ibid.

25. Ibid.


27. Ibid.


29. Ibid.

30. Ibid.


32. Nace, *Treating Alcoholism*.

33. Ibid.

34. Ibid., 170.


38. Ibid.


45. Ibid.


47. Ibid.


50. Ibid.


52. Ibid.


54. Ibid., 222.

55. Ibid., 222

57. Ibid., 222.

58. Ibid.


61. Ibid.

62. Ibid.


65. Ibid.

66. Ibid., 30

67. Ibid., 30


70. Ibid.

71. Ibid., 45.

72. Bentall, Mosher, and Reed, *Models of Madness*.


74. Ibid., 14.


76. Ibid.

77. Ibid.


79. Ibid., 18-19.
80. Ibid., 19.


82. Ibid.


87. Ibid.


94. Ibid., 16.


96. Ibid., 176.


100. Ibid.

101. Ibid.


104. Ibid.


108. Ibid.


110. Ibid.


112. Ibid.

113. Ibid.


117. Ibid.


121. Ibid.

122. Ibid.

123. Ibid.


126. Ibid.
Chapter 4


6. Ibid., 12.

7. Ibid., 23.

8. Ibid., 82.

9. Ibid., 82

10. Ibid., 40.

11. Ibid., 41.


Chapter 5