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THE ISPS CONFERENCE 2019 FREEBOOK

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ISPS
THE INTERNATIONAL SOCIETY FOR PSYCHOLOGICAL AND SOCIAL APPROACHES TO PSYCHOSIS

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ABOUT THE ISPS

ISPS is an international organization promoting psychological and social treatments for persons with psychosis (a term which includes persons diagnosed with "schizophrenia"). We are committed to advancing education, training and knowledge of mental health professionals in the treatment and prevention of psychotic mental disorders. We seek to achieve the best possible outcomes for service user/survivors of psychosis by engaging in meaningful partnership with health professionals, people with lived experience, family members and carers.

This FreeBook provides an introduction to recent publications from the ISPS book series, an essential resource for those wanting to consider aspects of psychosis in detail. Combining rigorous, in-depth intellectual content with accessibility, as well as professional and user perspectives, this FreeBook explores topics including personal experiences of psychological therapy, art therapy for psychosis and CBT for psychosis.

As you read through this FreeBook, you will notice that some excerpts reference other chapters; please note that these are references to the original text and not the FreeBook. If you are in search of more in-depth coverage of any of these topics, all of the titles featured are available in full from our website.

INTRODUCTION

ANNA LAVIS AND ANDREW SHEPHERD

This e-book offers an introduction to the three most recent books to be published in the International Society for Psychological and Social Approaches to Psychosis (ISPS) book series. Varying in topic, approach and even terminology, these extracts give a glimpse at the breadth of the discussions about psychosis and its treatment found in the series and, more widely, in ISPS. Both seek to foster inclusive debates that change conversations at a societal level. To this end, the book series supports the organisation's growing emphasis on social approaches to understanding and responding to psychosis. Underpinned by evidence of the entanglement of genes and physiology with social and environmental contexts, this perspective lies at the heart of this conference's emphasis on "the circular relationship between alienation and psychosis and the healing power of human reconnection." As such, it joins a focus on psychological and psychoanalytic approaches that has been core to ISPS's ethos and aims since its inception.

ISPS began with symposia, the first of which - the 'International Symposium for the Psychotherapy of Schizophrenia' - was held at the psychiatric clinic at the University of Lausanne in Switzerland in 1956. There, dissatisfied with the reductionist orientations of much mid-century European psychiatry, Gaetano Benedetti and Christian Müller, drew together colleagues to explore the potential of psychoanalysis to offer new ways of approaching psychosis therapeutically. This first symposium was followed by others later in the 1950s and into the 1960s, attended mainly by delegates from Switzerland, Germany and France, and in 1970 the first informal executive committee was convened. In contrast, over the following two decades an increasingly biological psychiatry, emanating from the US in particular, pursued physiological explanations for psychosis. This contributed to the need for ISPS to develop a more sustained and broader range of activities to promote psychological and psychoanalytic perspectives. In the mid 1990s, thus, under the guidance of Brian Martindale, Johan Cullberg and Endre Ugelstad in particular, ISPS - then called 'The International Society for the Psychological Treatments of Schizophrenia and other Psychoses' - was established.

Now, under its current name, ISPS comprises a diverse range of individuals, networks and institutional members from across more than twenty countries. Still at the forefront of advocating for psychosocially informed understandings of psychosis, the organisation recognises the humanitarian and therapeutic potential of these to foster and support personal recovery and wellbeing at all stages of psychosis, from early onset to more lasting experiences. As such, ISPS embraces a wide spectrum of therapeutic approaches from psychodynamic, systemic, cognitive, and arts therapies,

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to need-adapted and dialogical approaches, family and group therapies and residential therapeutic communities. In so doing, the organisation's activities are key to a growing international recognition of the psychological, social, and cultural factors that may have considerable explanatory traction as well as distinct therapeutic possibilities. ISPS also continues to strongly advocate for research into psychosis and it is this aim that is particularly supported by the book series.

By working with authors and editors with a variety of personal and professional experiences of psychosis, the book series showcases cutting edge research and understanding across disciplines and fields of practice. It seeks to foster inclusive discussion and debate to which lived experience perspectives are central. Of the books presented in this volume, it is perhaps Peter Taylor, Olympia Gianfrancesco and Naomi Fisher's book, *Personal Experiences of Psychological Therapy for Psychosis and Related Experiences,* that most explicitly demonstrates this emphasis on a multiplicity of perspectives. The snapshot offered here of its discussions of the myriad psychological approaches now available to people living through psychosis is accompanied by extracts from two books that focus on specific therapeutic approaches: *CBT for Psychosis: Process-Orientated Therapies and the Third Wave,* edited by Caroline Cupitt and *Art Therapy for Psychosis: Theory and Practice,* edited by Katherine Killick. Each of these three featured books approaches its topic in an accessible, thoughtful and critical way. Together they thereby illuminate themes that cut across different therapeutic approaches, as well as transcend these to speak to the experience of psychosis more widely.

Arguing for the value of art therapy in the treatment of psychosis, Katherine Killick describes the "particular forms of relatedness that can develop between therapist and patient in specialised forms of art therapy." She suggests that these "rely on the therapist's appreciation of and respect for the particular form of suffering experienced in psychosis." In turn, Caroline Cupitt proposes CBT as "an effective method for working with psychotic experience," suggesting that third wave CBT has "a focus on process rather than content, and being more concerned with someone's relationship to experience than the content of experience itself." Common to both of these discussions is an emphasis on respecting a person's own relationship to, and interpretation of, their experience. Aligning with the ethos of the Hearing Voices Movement, survivor advocacy and research more widely, these extracts reach to the heart of ISPS' aims; they advocate for therapeutic approaches forged through 'listening' to support a person's own processes of 'coming to terms'. Or, as Annie Blake writes in this volume, "the key way in which therapy helped me was by helping

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me make sense of what had been labelled psychosis and mania." Maurizio Peciccia and Simone Donnari also underscore the importance of an approach that allows therapy to build on, rather than destroy, a person's own meaning making by describing the art therapy technique of progressive mirror drawing as a space in which a client can "draw and dream with a therapist."

Each of these extracts, thus, highlights the fundamental importance of the relationship between therapist and service user. Seen most explicitly in the twinned contributions of Annie Blake, Amanda Larkin and Peter Taylor, this emerges as a key component of acceptable and successful therapy across approaches and models. However, it is also important to recognise, as Katherine Killick reminds us, the "traumatic threat" that a relationship with a therapist can present to a person. Moreover, as Rai Waddingham puts it in this volume, there is a need to consider that any therapeutic approach may "steal and reframe my own way of making sense of my story." In thereby highlighting the contradictions, limitations and power imbalances that may accompany the healing potential of any experience of therapy, her words also speak to a wider reflection on the struggles over legitimacy and what counts as evidence within current treatment landscapes.

Of talking therapies, Rai Waddingham asks "can such approaches really be integrated within a psychology that is concerned with scientific validity, or are they at risk of being subsumed into larger theoretical frameworks that dilute and warp their nature?" This is a perpetual consideration of the book series; we seek to offer texts that disrupt existing notions of legitimacy and hierarchies of evidence. To do this, our authors and editors approach psychosis as more than, in Annie Blake's words, a "tick list of symptoms." They consider "the nature of psychosis" as Katherine Killick puts it, from myriad perspectives and across a range of scales. Key to this, across the book series, is an acknowledgement of what Rai Waddingham terms the "collective knowledge base" of people with lived experiences.

Crucially, paying attention to the meanings, stories and experiences of people themselves reminds us that psychosis is a "biographical facet of the human being" as Gaetano Benedetti himself argued at the ninth ISPS symposium, as far back as 1988. This recognition underscores the need to think beyond the individual person to the social, cultural and political contexts in which they live. Mental distress is an embodied psychosocial experience that must be understood in relation to a person's life history and circumstances.

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In this volume, Peter Taylor and Olympia Gianfrancesco describe how psychosis can be about "being out of touch with the world around us." Shared by the following extracts, the book series, and the current conference, is a recognition of the circularity and context to that sense of alienation. Social exclusion and other inequalities may lead to the development of psychosis, as well as ensue from this. Yet, although the social determinants of mental ill-health and distress are widely known, there remains an entrenched disconnect between this recognition and the treatments widely available to people living through psychosis. That is, the question raises itself, as to what extent can a sense of alienation be addressed solely through 'treatment' with medication or therapy which is poorly attuned to, or disruptive of, an individual's needs? There is a need to bridge this divide and reflect on psychosis in the context of wider social, cultural and political environments and structures. As such, however, as Rai Waddingham cautions, we cannot "simply swap narrow biological responses for narrow psychological ones." Instead, extending katherine Killick's call for "places for the mind to heal," we suggest that such places should be as much 'societal' as they are 'clinical'. Healing is a process that necessarily implicates, as well as casts a mirror onto, society.

The process of making sense of a person's distress represents a fundamental existential challenge for all of us. In particular, working with experiences of isolation, deprivation, alienation and psychosis necessitates opening channels for discussion, compassion and the witnessing of distress or trauma. We hope that the book series can, in some small way, serve as one vehicle through which each of these aims is realised, thereby furthering the work of ISPS as a wider organisation, or, even, a family.

To support this aim, the book series benefits from the advice of an editorial board whose members are drawn from across the ISPS community:

www.isps.org

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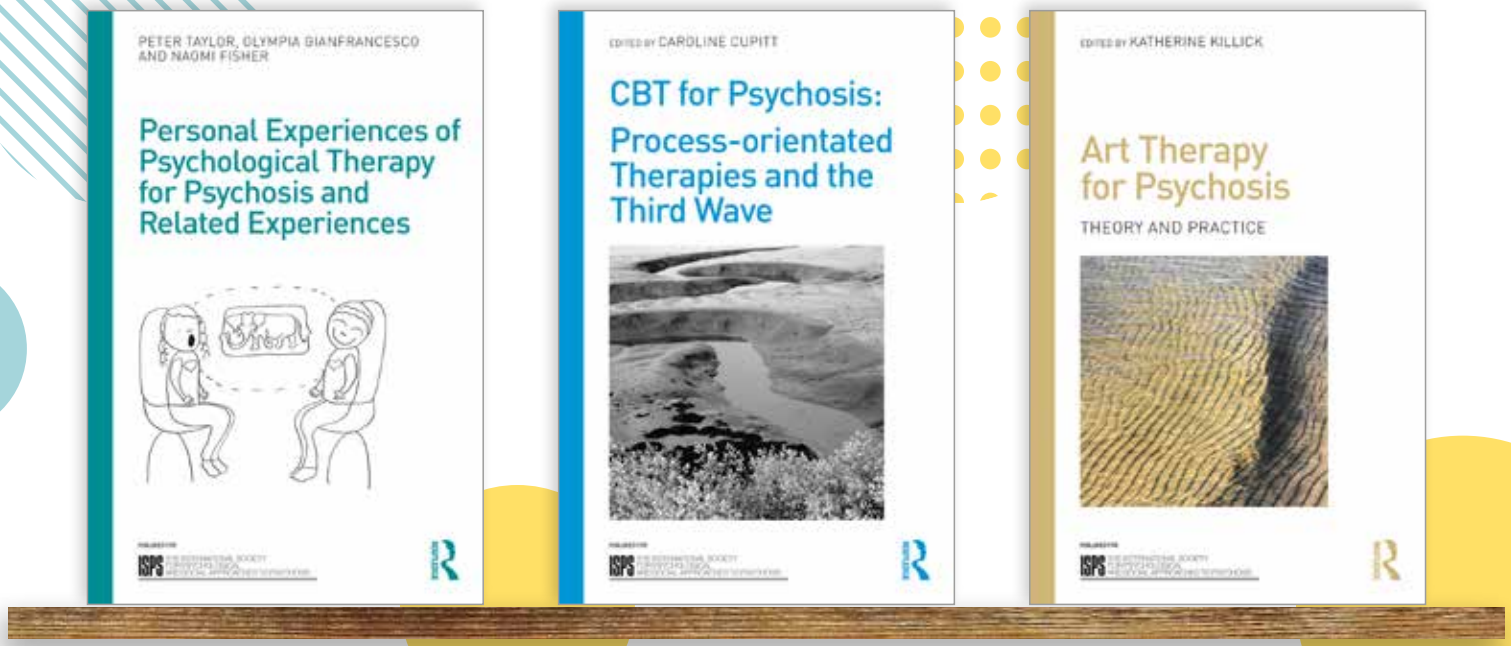

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CHAPTER

1

INTRODUCTION TO THE BOOK

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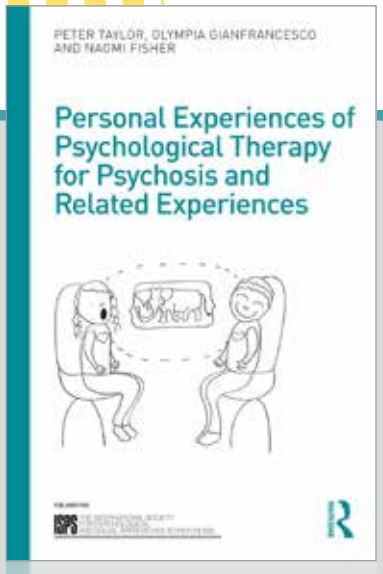

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Personal Experiences of Psychological Therapy for Psychosis and Related Experiences

Edited by Peter Taylor, Olympia Gianfrancesco and Naomi Fisher

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Peter Taylor and Olympia Gianfrancesco

Excerpted from *Personal Experiences of Psychological Therapy for Psychosis and Related Experiences*

OVERVIEW

The main goal of this book is to give an overview and introduction to a variety of different psychological or 'talking therapies' that are aimed at helping people who are struggling with experiences of psychosis. We do this in two ways:

by sharing the first-hand experiences of individuals who have received these therapies; and 2) by sharing therapists' accounts of the therapies they provide. In this first chapter, we aim to give a general introduction to the book. In particular, we explain some of the terms used in the book, including 'psychosis' and 'psychological therapy'. We also give a rationale for the book and discuss who may benefit from reading it. Lastly, we consider the benefits of looking to first-hand accounts in order to learn more about a therapy, and also some of the challenges in doing this.

WHAT DO WE MEAN BY PSYCHOSIS?

The word 'psychosis' does not refer to one thing, but in fact covers a broad range of very different experiences. A number of these involve some sense of being out of touch with the world around us. For example, some experiences associated with psychosis include hearing voices that others cannot hear, and having strongly held, unusual beliefs or ideas that appear to be unsupported or excessive (British Psychological Society [BPS], 2014; Freudenreich, 2007). These experiences may be distressing for some people, but not necessarily for everyone. Unfounded or excessive fears that others will hurt you or wish you harm, usually called paranoia, are another common experience of psychosis. Psychosis can also include a loss of motivation (avolition), and social or emotional withdrawal.

Traditionally, these experiences have been linked to particular psychiatric diagnoses, most commonly, schizophrenia. However, in recent years there has been much debate about how valid or helpful these diagnoses are (Bentall, 2017; BPS, 2014). There is now evidence that many experiences of psychosis exist on a continuum (e.g. Shevlin, McElroy, Bentall, Reininghaus, & Murphy, 2016), and that experiences of psychosis are common, to a greater or lesser extent, across the population, including people whom we would normally say are mentally well and people who might traditionally be seen as mentally unwell. In this chapter we refer to psychosis, rather than to a specific diagnosis, for the same reasons. One implication of seeing psychosis in this way is that it suggests that, for many people, psychosis is not a problem. Some people may hear benign or even supportive voices for example, which do not negatively affect their lives or how they feel. However, for other people,

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psychosis can be very difficult and disruptive. For some, the psychosis itself may not be their main problem, but the way it affects their lives. For example, it may prevent them going outside, meeting people, doing the things they would like to. It is not uncommon for people struggling with their psychosis to feel anxious or depressed at times. As a result, therapies that are designed to help people with psychosis may focus on the experiences of psychosis itself, but may also focus more on related problems, such as low self-esteem or low mood.

It is important to note that there is still much debate around the idea of psychosis, and some people would question the definition we give above. Some would argue against the use of the word 'psychosis' at all, due to the psychiatric con- notations and the stigma that can become linked to such words. We feel the term 'psychosis' is helpful in outlining a set of particular experiences (e.g. hearing voices, paranoia), but would agree that it has its limitations. Here we have given a relatively brief definition of psychosis, and we would suggest that those interested in knowing more about it do further reading on this subject or talk with a health professional about this (for example see BPS, 2014).

WHAT IS PSYCHOLOGICAL THERAPY?

As with psychosis, there is no single thing called 'psychological therapy'. Instead, a wide range of different types of therapy exist. What many have in common is that they rely on conversation between the therapist and the client as a means of bringing about improvements in the client's problems (although some approaches such as art therapy are a little different, in that they do not rely on conversation). Some individuals may be sceptical about the idea that simply talking about their problem could bring about any meaningful improvements in the problems they are facing. However, it is common for people to discuss their difficulties with supportive others (e.g. friends, family), and such conversations have the potential to be helpful, changing how a person feels, or how they see their problems. Thus, the idea that conversation alone can be helpful does not seem so far-fetched. Also, for many therapies, the conversations that take place in therapy serve the purpose of trying to bring about a change in a person's day-to-day life, such as in the way they cope, interact with others, or think about themselves and the world around them. Through such day-to-day changes, improvements in a person's problems can emerge. Different therapies make use of a variety of different techniques and tools to help achieve improvements for the client.

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PSYCHOLOGICAL THERAPY IN PSYCHOSIS

Over recent decades we have seen a growing recognition of the value of psychological therapies for people who are struggling with mental health difficulties. Research has steadily grown into understanding how these therapies can and do help many individuals with a wide range of different problems, from depression to anxiety, to problems with using substances or alcohol (e.g. Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Linde et al., 2015). The growing recognition of the value of psychological therapy has also extended to psychosis. This has been aided by increasing evidence that psychological mechanisms such as differences in the way individuals perceive others and the world around them, reach conclusions, cope with difficult feelings, or think about their problems, may be important to understanding their experience of psychosis and the associated distress they feel (e.g. Bentall et al., 2014; Dudley, Taylor, Wickham, & Hutton, 2015; Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002). We have started to see evidence that talking therapies do have a role to play in helping people who are struggling with psychosis (BPS, 2014), including specific psychosis-related expe- riences like hearing voices (e.g. Thomas et al., 2014). One good example of this is that psychological therapies are now recommended as a front-line treatment for people with experiences of psychosis in some national guidelines (e.g. National Institute for Health and Care Excellence, 2014).

This is not to suggest, of course, that there is no longer any controversy around the use of psychological therapy for psychosis. Many people still dispute the value of such therapies, and debate continues (Kinderman, McKenna, & Laws, 2015). Nonetheless, our own perspective is that evidence coming forward from trials and research studies suggests that psychological therapies can help people who are facing problems associated with psychosis. However, debate remains about which therapies are most effective for experiences of psychosis, or which aspects of a particular therapy are most important in helping clients. Different therapies may look similar to the individual receiving them. Alternatively, the same therapy may be practised differently depending on the therapist, and the same therapist may alter their way of working for different clients even whilst using the same therapy model. Moreover, there is evidence that the relationship between client and therapist is particularly important in determining the outcome, irrespective of the type of therapy being used (e.g. Goldsmith, Lewis, Dunn, & Bentall, 2015; Horvath, Del Re, Flückiger, & Symonds, 2011).

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THE CHALLENGE OF CHOICE

The growing recognition of the value of talking therapies for mental health problems has led to an explosion in the range of different talking therapies that are available. This has been the case for therapies for psychosis, as with other types of problems. Whilst for some, the possibility of having a choice between different therapies can be empowering, it also has the potential to be bewildering and confusing, especially if we know little about what these therapies involve or how they differ from each other. What is the difference between Cognitive Behavioural Therapy (CBT) and Cognitive Analytic Therapy (CAT)? Which would I prefer? Which of these focuses more on my early experiences? How will they make sense of my problems? It does not help that many therapies have similar sounding names and abbreviations: CAT, CBT, CFT (Compassion Focused Therapy). The decisions we can make about which therapy to go with are of course limited by various factors, not least the services available to us. Mental health services for people with psychosis are usually limited to a small number of different therapeutic approaches. In the UK, for example, available therapies are usually those that currently have the most developed evidence (e.g. CBT, Behavioural Family Therapy) and which are recommended by national bodies (e.g. National Institute for Health and Care Excellence [NICE]). However, even in such contexts, there is still a choice to be made about whether to take up the offer of a particular therapy. In order to make an informed choice about whether or not to pursue or become involved in a particular therapy for psychosis, we need to know something of what that therapy involves and what it is like. This brings us back to the main aim of this book: to provide an introduction to, and an overview of, a variety of different therapies for psychosis. The accounts of therapists explaining what their work involves are clearly helpful here, but only provide half the story. First-hand accounts from people who have received a particular therapy are also very important. In the current book, we therefore offer a combination of first-hand accounts of different therapies and accounts written by the therapists who deliver these approaches.

Although it has not been possible to cover every therapy in this book, we do cover a number of the dominant and recommended therapies for people with experiences of psychosis within the UK, including CBT and family therapy, as well as more recently developed approaches such as CFT. This book also focuses on therapies aimed at adults, which can differ to recommended therapies for children, and on therapies for individuals or families, rather than groups (although group therapies for psychosis also exist).

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THE POWER OF THE FIRST-HAND ACCOUNT

Learning about others' experiences of a particularly therapy is a helpful way of gathering information about that approach and deciding whether that is the therapy for us. In other, perhaps more mundane aspects of life, it is common to check others' experiences before we make decisions, such as booking a holiday or picking a restaurant. The choice of whether to take part in therapy, or of which therapy to undertake, is clearly a bigger decision, and so knowing what others went through when they received these therapies can be helpful. First-hand accounts are informative because they can go beyond just giving us an idea of what tasks and discussions a particular therapy may involve, and can describe how it may feel to experience that therapy. Such accounts are valuable not just in identifying some potential strengths and benefits of a particular therapy, but also in noting some possible challenges and difficulties.

Despite the value of considering others' experiences when making up our minds about therapy, there also needs to be some caution here. Everybody's experience of therapy will be different, even if they receive the same type of therapy. A huge array of factors will play a role in an individual's experience of therapy, some relating to themselves (e.g. their expectations and goals for therapy, their own understanding of their difficulties), and some relating to external factors (e.g. the qualities and preferences of the therapist, the nature of the service). A particular therapeutic approach, like CBT, does prescribe a certain set of methods and techniques. However, the way one therapist applies this approach may differ from that of another therapist. As a result, first-hand accounts of therapy provide a useful guide or outline of what a therapy might be like, but we can never assume that our own therapy journey will feel quite the same. This caution can also be extended to the accounts written by the therapists themselves, of course, because as noted above, one therapist's way of working may differ to another's.

It is also important to note that one person's account of their therapy does not necessarily constitute evidence that a particular therapy does or does not work. There is ongoing research with the goal of determining which therapies are helpful, in what way and to whom. One of the challenges facing the researcher is that if any single individual gets better after receiving therapy, it is hard to know why. Perhaps the therapy helped them, but perhaps they would have got better anyway, or perhaps it was just the act of talking to someone about it, and so nothing special about that particular therapy that helped. It could even be that something small, like the act of regularly travelling to see the therapist, was enough to bring about some

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improvement. Researchers draw upon various methods and approaches, and look at the experiences of large numbers of people, to establish whether it is the therapy that helps, as opposed to some other unknown factor. Considering this, we can see that an individual first-hand account where someone found a therapy helpful does not necessarily provide good evidence that therapy will work for most people. For this reason, we would suggest that, in considering therapy, it is important to also consider the evidence that currently exists for that therapy. Within this book, the chapters written by therapists provide a brief overview of the research behind each approach.

ABOUT THIS BOOK

We hope this book will be helpful for a number of different people. We particularly hope it will assist those who have been offered therapy, or are seeking a referral for therapy to help with difficulties related to psychosis, and the friends and family of people in these situations. We also hope this book will be of value to therapists and other clinicians (and those training in these professions), either as a resource to pro- vide to clients, or to support their own learning and development as practitioners. Indeed, our own opinion is that there is much to be learned from first-hand accounts for the therapists themselves in terms of how they introduce and conduct therapy. Many of the therapies covered in this book, whilst used in the UK, are also used internationally (e.g. CAT, CBT, family therapy, open dialogue), and so we believe this book will be relevant to many readers from around the globe.

The book has been structured so that each chapter concerns a different therapeutic approach. Within each chapter there is a section giving a first-hand account of the therapy, and a section giving an introduction to that therapy from the perspective of the therapist. In putting this volume together, we are particularly indebted to those who have shared their experiences, progress, and achievements, as well as their difficulties. The chapters have demonstrated to us both the potential for therapy to change the lives of those who are faced with the challenges that psychosis can bring.

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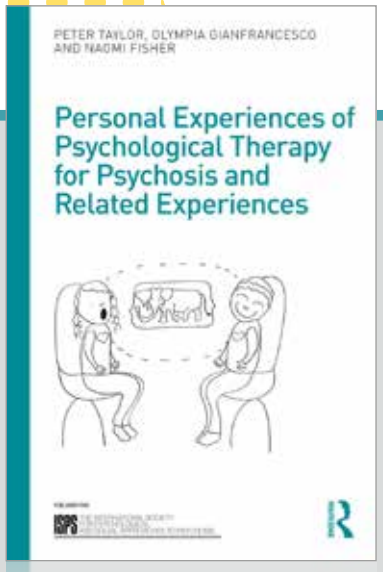
'In search of help', a short comic on experiences of therapy by Annie Blake

CHAPTER

2

THE RELATIONSHIP WITH THE THERAPIST

Annie Blake, Amanda Larkin and Peter Taylor



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THE RELATIONSHIP WITH THE THERAPIST

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Throughout this book we have so far focused on specific therapies and approaches. However, there are many 'common ingredients' that different therapies share. These common ingredients include the quality of the relationship between client and therapist, and this seems potentially important when it comes to determining the outcome of therapy. In this chapter Annie shares her account of integrative Cognitive Behavioural Therapy, but a key theme is the relationship she builds with her therapist. This is something that Amanda and I then pick up and discuss further in the second section of this chapter.

– Peter Taylor

INTRODUCTION

In the autumn of 2012, I found out that my father had been arrested for the possession of child pornography. He was also threatening to commit suicide. Up until that point, I had a good relationship with my father. I looked up to him and respected him. The trauma of discovering this revelation and the mental pressure of my mind's attempt to make sense of a senseless and incomprehensible situation triggered a manic psychotic episode. A year and a half later, I embarked on six months of Cognitive Behavioural Therapy (CBT) for psychosis. In this chapter I plan to explore how therapy aided my recovery. I will cover which topics to expect in therapy sessions, (e.g. family, relationships, attitudes and commitment to therapy), different exercises I found useful or challenging, how I see the roles within a therapeutic relationship, the context of my difficulties, and how therapy gave me practical tools to confront painful issues, be kinder to myself, and begin to let go of the past and move on. In this chapter, all real names have been replaced with pseudonyms in order to maintain confidentiality.

ACCESSING THERAPY

The practical requirements for therapy are minimal. On the face of it, all that is

needed is a small and at times stuffy room, two chairs, and a strategically placed tissue box. If you are lucky there might be some artwork on the wall. Just two people in a room, talking. It is remarkable then, how through this simple set up, such transformative personal developments are possible.

My first experience of seeking out and getting therapy was out of desperation. My

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brother had died five years earlier and I had just come out of a five year relationship with one of his friends. I felt in utter despair, experiencing frequent suicidal thoughts. When I was referred to have six weeks of therapy sessions I had no idea what to expect. I just felt I was having an existential crisis and would try anything to take the pain away. I kept a diary and wrote down my nightmares. I also read a book about how therapy had assisted other people, called 'Love's Executioner' by Irvin D. Yalom (1991). I found this very helpful, and after six weeks, the depression I had been experiencing for the last two years lifted. So when I approached my more recent period of therapy, which will be the focus of this chapter, I already knew a few things that might help make the sessions more successful. Keeping a diary is a way of ordering your thoughts, making notes of what you would like to bring up, and reflecting on what you have covered in a session. This helped me enormously.

I think it is important to assess for yourself when the time is right for therapy, although it could be a good idea to get yourself on a waiting list for therapy even when you are not feeling like it, as you may have changed your mind by the time your name gets to the top. One gauge for how ready you are feeling might be how optimistic you are that talking therapy could complement your other coping strategies on the path to recovery. My most recent experience of therapy, with CBT, involved a commitment to keeping weekly appointments for six months. Commitment, a positive attitude, and a belief that I could make sense of psychotic and bipolar experiences through being open about my memories and feelings from these periods helped me enormously. The remainder of this chapter will focus on my experience of CBT.

TELLING MY STORY

In my experience, talking to a therapist is very different from talking to a friend. In friendships, boundaries and agendas may not be clear. While suffering with mental health problems, it can be very hard to discuss the disturbing and distressing elements of your issues like suicidal thoughts, paranoia, delusions, and feelings of being out of touch with reality, through fear of being a burden or being misunderstood. By speaking out, it can sometimes feel like risking further isolation and alienation. My role, as I saw it, was to be as open and vocal as possible about my experiences. I found the role of the therapist was often to be a sounding board which reflected my perceptions back to me but with new and consistently useful insights. It was a focused partnership. There were also clear, unspoken boundaries between us. At times I felt curious about my therapist's life. I would wonder how his week had been or imagine what his home was like or if he had a partner. Due to my respect for

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the boundaries I felt, which were about him being a professional who was employed to listen and help heal me, I had the feeling that it would have been inappropriate to ask him about his personal life and this prevented me from asking any questions which may have crossed this line.

The therapist who delivered my CBT was called Sone. Early on in therapy I was asked (along with the numerous questionnaires I was asked to fill out) what I wanted to get out of therapy and if I had any goals. I said I would like to try to make sense of my psychosis. The main goal I had was to come to some kind of resolution with regard to the feelings towards my father. I knew this was a big ask but I also knew that at the root of my episode were the fears, shock, and terror that had sprung from finding out that my father was not the man I thought he was. I began by describing in great detail what had happened during my manic psychotic episode. This took up three hour-long sessions, which I think gave the rest of my sessions a very firm foundation, as I truly felt that my therapist understood what I went through. I showed my therapist a sketch book I had made just after my episode with drawings and writing about my experiences. I also surprised myself by how much I could remember, the insomnia, the automatic writing, the over spending, the Truman show complex, delusions of grandeur, paranoia, increased energy. I ticked all the manic psychosis boxes, but alone and without context, I find these labels of symptoms hollow and lacking in meaning. It is hard to generalise when everyone's experiences of these symptoms are so different. So I spoke in great detail about the nature of my psychosis, what I could remember happening and how I felt looking back.

One example of the things that we covered in the sessions was how, in a great state of agitation and having had little sleep, I went to a charity for elderly people and demanded a wheelchair for a woman I knew with a heart condition and limited mobility. Her name was Beatie and I volunteered to walk her dog for her on a regular basis. At this point I was convinced that my father was trying to kill me and that there were hitmen outside the charity shop. I also believed I was having telepathic visions of my father, as Satan, in a straightjacket. When I looked at all the pamphlets on display, I saw messages in the words just for me. Everything held a mystic significance to me. I had asked for the wheelchair for Beatie because when I was at her house, before the revelations about my dad, she had said that she wanted to go shopping and did not have the means to go out alone. The staff at the elderly people's charity could see that I was not functioning normally. On the way over to Beatie's house, I started talking in a deep voice about my dead brother and then I felt as though my brother was talking through me.

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Excerpted from *Personal Experiences of Psychological Therapy for Psychosis and Related Experiences*

I spoke about how I believed that my brother had invented the Internet. I said that we were twins, but I had been frozen and our mother artificially inseminated five years after his birth. We got to Beatie's and I went upstairs to hide behind a cupboard because I thought someone was trying to shoot me through the window. Beatie was shocked and confused. A few weeks later I heard from the charity that Beatie's absent son had heard about what had happened and no longer wanted me to walk the dog. This is just one example of the devastating consequences of this kind of episode. I lost my home, my job, my friends, and my relationship with Beatie and her dog, Teddy. This is just one of the anecdotes I told my therapist, Sone, in an effort to describe how these symptoms manifested for me. In telling my story there was a great sense of catharsis.

Through my sessions, space was given for new life events such as, among other things, a break up in a new relationship. These important and emotional events sometimes took the focus away from my original goal, but my therapist was extremely accommodating, and I was able to shape the direction I wanted the therapy to take. By the end of therapy, we had identified three rough segments: psychosis and my father, relationships, and more generally how to lead a 'good life'. This was the general arc of therapy for me. Along that arc, topics were revisited and there was room for change and expansion depending on what was going on in my life.

Although naturally curious at times, I never felt the impulse to ask anything about Sone's personal life even though he knew so much about mine. This may seem unbalanced or one sided, but in fact it released me from the usual complexities of social interactions. The therapist's purpose is to focus their attention, knowledge, and compassion on you. The boundaries create a safe space where you are not obliged to take on the other person's worries, concerns, and day-to- day life circumstances. Yet my therapist regularly told me that he was learning from me and so the relationship became mutually beneficial. We learnt from each other.

EXERCISES AND INTERVENTIONS IN THERAPY

In each session I would tell Sone how my week had been, how I had been feeling, and what I had been doing. We would recap on what we had spoken about in past sessions and usually a natural focus for the session would emerge as we spoke. Often we spoke about the stresses and strains I was experiencing in my family life. My relationships with my mother and brother had been put to the test by the whole situation and especially by my hospital admission. I was still harbouring some anger

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and resentment toward them, as well as my father. By focusing on the way in which I was thinking about these relationships and my attitudes towards them, I was able to consider with Sone a range of ways I could perceive their actions. In turn this gave me insight in to different ways that I could respond in my behaviour towards them. This helped me to repair or accept certain aspects of these complex relationships.

This process involved a lot of standing back from the situation and analysing what may have been going on. When I was in a crisis it was very hard for me to separate myself from my emotions and I felt I was in a whirlwind of pain, anxiety, and stress. Therapy gave me the chance to look back and process my reactions and emotions. This gave me the chance then to look forward and consider fully how my behaviour now could best promote my recovery. By changing the way I was thinking about my past, it directly impacted on the way I could function for the better in the present. For example, I was holding on to a lot of anger at my mother for not leaving my father. I was almost blaming her out of association with my father. I discussed with Sone how my relationship with my mother was separate and existed in its own right. Then I went on holiday with my mother for a week to an animal sanctuary. Sone stressed how important this time was for us. By thinking about my relationship with my mother in a new way, and not connecting her so much to my father, I was able to enjoy the week away.

Over the six months of therapy, I recall doing three exercises that I found very useful. The first of these was in preparation for seeing my father. After almost two years of not speaking to my father, I was able to invite him to a therapy session and talk to him directly about how his actions had impacted my life. In preparation, I was invited to imagine that he was sitting in the chair in front of me and I was given the chance to rehearse all the things I would like to say to him. As I have a vivid imagination, I found it easy to put myself in this imagined situation, and although it was hard emotionally, I found the experience invaluable when it came to the day. In another exercise, I was invited to imagine that it was my 90th birthday party and several guests (alive or dead) approached me and told me what I had brought to their life. I immediately started crying as I visualised each guest. My dead brother was there, my best friend, and my dog. It was an amazing exercise for realising your self-worth and good qualities that others see in you. The third exercise was aimed at making more balanced decisions. I was invited to sit in one chair and give an account of all the reasons why I should do something, then sit in another chair and give all the reasons why I should not. Then sit in a third chair and give a more balanced assessment based on all the pros and cons. Perhaps it was my drama training that helped, but I found this exercise easy

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and enlightening. It was far more revealing than simply writing a list of pros and cons. After describing my psychotic, manic reaction to trauma, I spoke about the resentment I held towards my father. Sone said that resentment is like holding a hot coal, ready to throw at someone else, but that it is only hurting you. When it came to arranging a meeting, my father was very amenable and immediately said yes. With the above in mind, I wrote down my thoughts in preparation for the meeting, including reasons why I wanted to meet, what I would like to get out of it, how I see the relationship now, and what I need from him in the future. The way in which Sone facilitated the meeting helped me feel safe and prepared. I felt like finally I was taking some control over my life situation. Sone held the space expertly. He created a space in which I was able to tell my father exactly how his actions had negativity impacted my life. He also gave my father and mother a chance to speak, prevented anyone from talking over each other, and was there to

suggest a time out if emotions ran too high.

There is no simple resolution to the struggles with my father, but to have the chance to meet on my terms and express my pain to him in a controlled and safe place proved to be very cathartic, and in some ways released me from the heavy burden I felt from keeping my feelings inside.

I came to realise that perhaps my father was incapable of really empathising

with the torment I had been through, or with the horrifying consequences that those countless abused children had to face day by day. The most helpful moments were those which sprung from my and Sone's authentic mutual respect and honest connection. Rather than dictating the best way I should think or feel about a situation, Sone would gently offer his insights which might have signposted a direction of thought to me, but on which no pressure was placed to go down those trails of thought. More often than not, Sone would lead me to thinking about situations and relationships in new and different ways, and his insights would often trigger valuable realisations, leaving me feeling empowered that I could make my needs known without damaging connections. I did find the structured exercises helpful, but I think this had a lot to do with Sone's expert timing and the relevance of the exercises to the general flow of therapy. In isolation and without the sensitivity to know which exercises might be of use, I do not think they would have been as helpful. Therapy is such a personal journey and I believe everyone is ready at different times.

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HOW THERAPY HELPED

The key way in which therapy helped me was by helping me make sense of what had been labelled psychosis and mania. While studying at University, I had some lectures on mental health. This was before my bipolar diagnosis, but as it runs in my family and I was dating someone at the time who suffered from it, my attention was grabbed. Bipolar, psychosis, schizophrenia, they were all described using a tick list of symptoms, but the labels remained just that. The lectures gave me no insight into what the symptoms might look like in reality. I think words like 'delusional' and 'paranoid' need a context in order to gain meaning. That said, after days of insomnia as I gradually slipped into mania, I held that tick list in my mind and one by one mentally crossed them off as I experienced each symptom. For a long time I felt health care professionals saw me as a tick list of symptoms and it was not until I met Sone that I truly felt someone was hearing my trauma and the potential meaning in my madness. Sone gave the space for the possibility that my episode was my mind's way of coping; a necessary escape from a reality that was too overwhelmingly harrowing to cope with in any other way; a normal reaction to an abnormal situation. This allowed me to actually value my experience, however painful it was, rather than feel ashamed and pathologised as I had done in the past. The stigma of being branded bipolar still burns bright in my psyche, and for a long time I lived in denial, but therapy helped me see that I am so much more than my condition. I have heard bipolar being compared with asthma. People with asthma are not constantly having an attack, for most of the time they are asymptomatic, as am I. I know this is not the case for all people who have bipolar, but I found it a useful comparison for me.

Therapy built my resilience, which has been tested a great deal in the year and a half since I finished therapy, including another hospital admission. I do feel therapy gave me the hope to bounce back and the grit to carry on when I felt in utter despair. We explored practical tools such as the exercises I have described, writing a journal and more willingly expressing my needs to others, along with others such as meditation, mindfulness, exercise, and limiting my alcohol intake. These are all very helpful, but ultimately it was a matter of rebuilding my self- esteem and my sense of control over my life, which has most helped in my journey of recovery and staying well.

I resented the feelings of being judged by health care professionals who neglected to take a thorough history of my past traumas or current challenges. With going to therapy though, I often felt like I was stepping in to a warm bath. I felt safe, secure, listened to, and cared for. Despite my past, I did not have a problem opening fully to the experience of therapy and to the trust I had to forge with my therapist for the

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relationship to be fruitful. Therapy also allowed me to listen to myself and my instincts more readily. I am aware that CBT can be challenging for many, the family sessions I had, seeing my dad again, were particularly hard, but on the whole my experience of therapy was extremely positive, and the sessions became something I looked forward to each week.

I am still striving to find balance in my life, and doing all I can to come to terms with the traumas I have experienced. Six months of therapy did not prevent a relapse in my case, but without having been to therapy and gained so much insight into my difficulties, I know I would not have been able to cope so well with a second period spent in hospital and the aftermath of that. In therapy we discussed my triggers and early warning signs. I had already drawn up a comprehensive relapse prevention plan with my social worker, but it was the holistic approach to healing which has really helped me. The mysteries of the mind are vast and deep, and bipolar is a devastating and unpredictable condition. Therapy may not have stopped me from having another episode, but it has certainly contributed to me making the most of my life when I am well, and in dealing with the consequences of a manic episode and the crushing hopelessness of depressive symptoms. It has made me realise that I can and do have an influence on my external environment, and that in every area of my life I can learn to help myself.

CONCLUSION

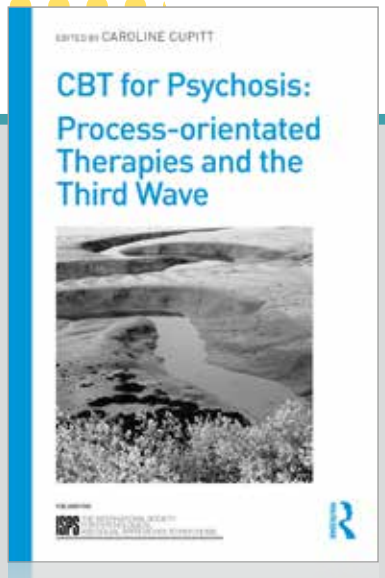
Therapy has had a lasting impact on my life. It has changed the way I relate to my experience of mental illness in such a positive way. Although I still make mistakes and have setbacks, it has allowed me to be more honest and truthful in my relationships, both platonic and romantic. I have been much more able to recognise my emotional landscape and have a greater knowledge of the path which is best for me. In my experience, a therapist may not talk about their training or the technicalities of how they deliver their treatment. Inherent in the therapeutic relationship should be that they have your best interests at heart and that you can trust them to guide the sessions in such a way that leaves room for inevitable life changes and developments, but also gives space to address goals and concerns you have at the start of your therapy. Ultimately, the healing begins when there is a genuine meeting of hearts and minds. It starts with connection, and can grow into a life changing experience which offers hope, insight, and dignity.

CHAPTER

3

INTRODUCTION

Caroline Cupitt



This chapter is excerpted from

CBT for Psychosis: Process-orientated Therapies and the Third Wave

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INTRODUCTION

Caroline Cupitt

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Cognitive Behaviour Therapy (CBT) for psychosis is said to have started in 1952 with a single case study by Aaron T. Beck (Beck, 1952). It was not until the late 1980s however, once CBT for other conditions was firmly established, that attention turned more firmly to the experience of psychosis. The pioneers took as their starting point what were known as the two hallmark symptoms: hallucinations and delusions. What followed were a number of treatment manuals which outlined the approach (including Kingdon & Turkington, 1994; Fowler et al., 1995; Chadwick et al., 1996). If Behaviour Therapy is thought of as the first wave of CBT, this can be thought of as part of the second wave, in which a symptom-based approach to CBT for psychosis emerged as a significant force (Hagen et al., 2011). Proponents argued against the idea of a syndrome of psychosis, suggesting that CBT should be targeting specific individual symptoms.

During the 1990s, researchers worked hard to establish the efficacy of CBT for psychosis through a series of randomised controlled trials, many of which were conducted in the UK. These generally showed modest effect sizes, although the positive effects often outlived the therapy itself (Wykes et al., 2008). However, there was a debate about the measures used to evaluate CBT in these trials. As with research on the effectiveness of medications, the most commonly used outcome measure was the Positive and Negative Syndrome Scale (PANSS), which assesses a wide range of psychotic experiences – many of which are not the focus of CBT. What is more, the published manuals describing CBT for psychosis explicitly state that the therapy aims to reduce distress rather than symptoms. Arguably CBT was being evaluated as if it was a neuroleptic medication, rather than on its own terms (Birchwood & Trower, 2006). Nevertheless, this early work clearly established that CBT can be an effective method for working with psychotic experience.

As the results flowed through into guidance in the UK (NICE, 2002), the US (APA, 2004), Canada (CPA, 2005), Australia and New Zealand (RANZCP, 2005), Spain (Working Group, 2009) and elsewhere, there was hope that people within the mental health system experiencing psychosis could finally begin to expect a psychological approach to their distress. Unfortunately, despite CBT becoming widely recommended, access to the therapy has remained limited. There are many reasons for this, not least the limited numbers of suitably trained therapists available in many healthcare systems – but continued controversy about its effectiveness has also played a part, with some having argued that its effectiveness has been seriously overstated (Lynch et al., 2010). There are others who point out that in CBT generally, content-orientated cognitive change has not been shown to add very much to the effectiveness of previously established behavioural approaches (Longmore & Worrell, 2007).

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Given this context, it is therefore of no surprise that CBT-trained clinicians and researchers have sought to extend and improve the approach. This work has been informed by an increasing volume of studies demonstrating that voice hearing and unusual beliefs are common in the general population (Romme & Escher, 1989). Once the experiences themselves are not viewed as inherently distressing, there is the exciting possibility that they may not be *symptoms* at all, but rather aspects of human experience that only sometimes become problematic. The traditional focus on a person's appraisal of their unusual experiences now does not seem to go far enough: the underlying processes by which we all relate to difficult experiences are brought now into question.

The beginning of this change appears with an increased understanding of the role of metacognition. Morrison & Wells (2000) investigated the strategies people use to suppress unwanted intrusive thoughts, known as thought control. They found that people experiencing psychosis used more worry and self-punishment to control thoughts than the general population. It follows that understanding more about thinking, and specifically the uncontrollable nature of many mental events, offers the possibility of freeing people from the distress they may experience on hearing an unwanted voice. Metacognitive Training (Chapter 3) applies this understanding in a very accessible and normalising way. It is distinctive in taking an educational approach and regards change in metacognition to be central to relieving psychosis-related distress.

At a similar time, mindfulness techniques were being established for the treatment of depression. Chadwick (2006) saw these as offering another route to changing someone's relationship to psychotic experience, in this case using experiential exercises. Although at first these two developments appear very different, they share an emphasis on adopting a new stance in relation to experience. Someone in the midst of a distressing psychotic experience is being asked to observe the process without seeking to suppress or change the experience. Developing this kind of 'decentering' capacity is of course a part of traditional CBT (Hofmann et al., 2010), but previously it was typically spoken of in terms of rationalising thoughts. The introduction of mindfulness techniques provided a means to enable people to develop greater metacognitive awareness without simultaneously requiring them to change the content of thoughts or voices.

The more effectively someone is able to develop and utilise skills to unhook from a distressing experience, the less likely they are to rely on habits of experiential

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avoidance, which in turn creates the possibility of accepting – rather than battling against – the elements of experience that a person cannot change. Here we more firmly enter what is commonly considered the 'third wave' of CBT. Acceptance is not based on passivity or resignation, but instead on an understanding of the mind and its uncontrollable nature. CBT would previously have focused on reducing voice power and control by seeking to change someone's appraisal of the voice hearing experience. Now the horizon has expanded and a more relational approach is taken, in which the *process* of engagement with the experience is targeted, rather than a person's appraisal of that experience. In Acceptance and Commitment Therapy (ACT) this is spoken about as attention to context in order to change the function of psychological events (Hayes et al., 2006). It is an approach that values acceptance over change, albeit recognising that acceptance then brings with it change.

A difficulty with the concept of acceptance is that it can make it all sound too easy. Research tells us that the quality of someone's relationship with an unwanted voice is very similar to their other relationships (Hayward, 2003). Many people have suffered severe trauma and their voice content often reflects this. If trauma occurred early in life it may have affected someone's ability to conceptualise their own and others' mental states. It may also have made it difficult to relate to others with trust and confidence, be they embodied or just a voice (Chapter 2). In these circumstances, asking someone to accept the nature of their experience without also wishing to change it will not be straightforward. It requires people to considerably expand their repertoire of coping, in the context of a safe and secure relationship. One way of describing that change is in the development of more compassionate responses for the self and other (Chapter 6).

Collectively all these developments have at times been referred to as 'third wave CBT for psychosis'. However, they do not all identify as CBT or as third wave approaches (Chapter 9). For example, Compassion Focused Therapy, whilst described as arising from within the cognitive behavioural tradition, is now an approach in its own right (Gilbert, 2010). In other reviews of third wave CBT, different therapies may be included, and others left out. For example, in his review Kahl (2012) includes Behavioural Activation as a third wave approach. Although at first this might seem odd, there are striking connections between some third wave approaches and traditional Behaviour Therapy. For some, the third wave is part of a return to and reinvigoration of what would otherwise have been known as Radical Behaviourism (Chapter 5).

Difficulties defining third wave CBT have led some to argue that the concept should be abandoned. Hofmann et al. (2010) argue that these developments are simply an

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extension of what has always been 'a family of CBT approaches', which have in common the idea that cognition exerts a causal effect on behavior and emotion. Whilst there certainly is a debate to be had, there nevertheless does appear to have been an evolution in CBT over the last ten years which merits attention. It has excited clinicians, many of whom have adopted these new approaches in advance of their being subject to robust evaluation.

This book takes a pragmatic view, including the cognitive behavioural approaches that a practising clinician or client is most likely to encounter. It understands the third wave as having a focus on process rather than content, and being more concerned with someone's relationship to experience than the content of experience itself. Since this is a change of emphasis in CBT, rather than an entirely new idea, metacognition is included for this is where it all appears to start. Metacognition is important because thinking about thinking is the start of moving away from a focus on the content of thoughts. It has led to a form of therapy called Metacognitive Training (Chapter 3), in which people are explicitly taught about thinking. What is more, the principles learnt apply to all thinking and do not single out psychosis as a special case. As such, the approach steps firmly away from a symptom-focused perspective. However, this may only be the first step in understanding the role of metacognition in psychosis, which has the potential to take us into wider questions about the nature of the self (Chapter 1).

The Method of Levels (Chapter 7) is included in this book, although it is only part of the family of cognitive behavioural approaches in its broadest sense. It is a metacognitive form of therapy, which seeks to change someone's relationship to experience. It therefore seems to make the same kind of departure from traditional cognitive behavioural therapies that we see in the other, more obviously third wave approaches. It is also trans-diagnostic in approach, again moving us away from a focus on symptoms.

Mindfulness-based approaches (Chapter 4) and Acceptance and Commitment Therapy (Chapter 5) are centre-stage, widely regarded as third wave approaches. We begin with mindfulness because it forms part of the other, and yet is often also practised as an adjunct to traditional CBT. ACT is rapidly becoming the first order third wave approach, in part due to its originators' enthusiasm for the term (Hayes, 2004).

Compassion Focused Therapy (Chapter 6) also critiques the emphasis previously given to cognition within CBT, but is different in that it takes an evolutionary perspective. It explicitly seeks to work with the older affiliative motives and emotions,

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albeit using recognisably CBT techniques (Gilbert, 2014). Again it offers a trans-diagnostic approach and also the beginnings of a more social view of mental distress.

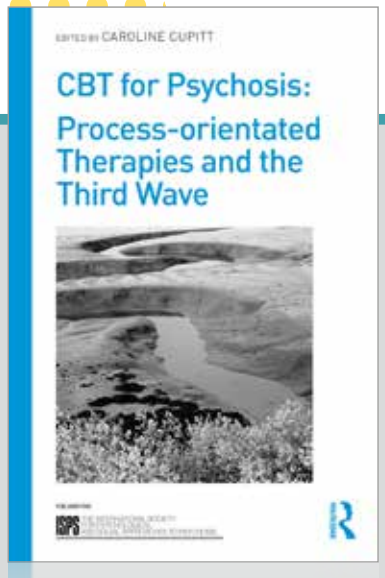
A book on process-orientated therapy and the third wave of CBT would not be complete without some critical reflection on these diverse developments. This comes firstly from someone who has experienced CBT (Chapter 8) and in the final chapter (Chapter 9) we ask the question of where next for both CBT and psychosis?

CHAPTER

4

A STEP IN THE RIGHT DIRECTION OR A MISSED OPPORTUNITY?

Rachel Waddington



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A STEP IN THE RIGHT DIRECTION OR A MISSED OPPORTUNITY?

Rai Waddington

Excerpted from *CBT for Psychosis: Process-orientated Therapies and the Third Wave*

I was first introduced to Cognitive Behavioural Therapy (CBT) whilst seeing a psychologist for help with the intense anxiety and emotional struggles I was facing at university. My memories of our two or three sessions together are largely positive – she was warm, easy to talk with and I got the sense that she really cared. I remember her giving me a sheet – *10 common thinking traps* – that left me feeling like she had an uncanny ability to read my mind. I could, almost effortlessly, give examples of each of them within my life. Naming these struggles felt helpful – it was as if we could target each one in turn, challenge it and return my mind to a place of sanity. Of course, she had no idea that I was struggling with voices and believed that I had an alien inside me that had the power to control me. It never came up in conversation.

There was something about the rationality of CBT that really appealed to me. Its solid structure felt like it had the potential to take something that was very messy (my life), untangle it and neatly file it away as thoughts, feelings and behaviours – so some years later, when my community psychiatric nurse (CPN) invited me to work through a CBT for Psychosis (CBTp) workbook with her I was happy to oblige. Still, working alongside someone who was as clueless as me didn't inspire confidence and I was soon inventing answers to questions that seemed irrelevant and unhelpful. I tried to show progress to keep the nurse happy, yet in truth I couldn't connect the dots between the worksheets and my experience. They seemed as if they were on different planets, and the nurse simply wasn't equipped to help me navigate the space between.

Thankfully, I had the privilege to meet a skilled CBTp practitioner whilst working in a service to support children and young people who hear voices. Coupled with a good working knowledge of dissociation and trauma, I recognised their deep respect for the client's own wisdom. I valued their willingness to work outside of the box rather than blindly follow the worksheets that constrained my own therapy. Still, I wondered how much of the healing I witnessed came via the quality of the therapeutic relationship, rather than the tools of the trade. I came to view CBTp as a potentially useful vehicle to enable practitioners to have useful conversations around difficult experiences. I saw it as a way of encouraging practitioners to pay attention to someone's relationship with the voices they hear and the beliefs that surround them. Some seemed able to use this structure to creatively engage with another human being; others found themselves wedded to an approach that was a poor fit for the person they were trying to help.

I have deeper concerns about the model of CBT. Its language, filled with terms such as 'misattribution', 'cognitive distortions', 'maladaptive', 'errors', 'biases' and 'faulty' hurt the part of me that has had to fight to recognise my experiences as meaningful

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and adaptive. This professionalised psychobabble, backed up with peer reviewed articles and Randomised Controlled Trials (RCTs), has the power to steal and reframe my own way of making sense of my story in a kindly formulation. It's an effort to sit with these feelings and gather the generosity of spirit needed to allow myself to look beyond this and acknowledge what CBTp can offer. It has, I believe, helped to place psychological approaches to psychosis within mainstream mental health practice. It has helped to make it okay for practitioners to talk about voices and engage with people's beliefs, pushing back against those long-held fears of collusion that have influenced so much of mental health practice. It has helped provide a useful framework for many people I consider allies. Yet it is not perfect.

A limitation that many recognise in CBTp is its focus on rationality and cognitive processes, when so much of what we believe and do as humans goes beyond this. Like many, I have the amazing ability to ignore the evidence and listen to my gut. This ability can be useful – it has led me to fight against the odds and take steps forward when others felt I would surely fail. However, it also means that all the rationality in the world won't provide me with lasting reassurance if my gut is consumed by terror. At those times, so-called rational thoughts feel like ill-fitting clothes whereas the feeling itself resonates with my core. Sure, sometimes the way I think can modify how I feel about something. But, with the deep stuff – shame, terror and rage – this approach barely scrapes the surface. Instead, attempts to modify my thinking merely promote a state of dissonance where I begin to disown or disavow my feelings-core. Given a choice between rational-me and feelings-me, I might understandably choose the rational one as it brings with it the promise of control. Yet such a separation is impossible to sustain in the long-term. Those feelings don't simply disappear, they fester underneath the surface and are handed back to me in a metaphorical and exaggerated form by the voices and the content of my overwhelming beliefs. Such emotional suppression gives my voices and beliefs more fuel.

USHERING IN THE THIRD WAVE

I first heard about third wave CBT approaches at the 2012 World Hearing Voices Congress in Wales. During a hot debate around CBTp, I heard Rufus May speak about the new third wave developments and their focus on emotions and compassion. Instantly, I perked up. Compassion and curiosity have been essential companions in my own journey and the idea of CBTp embracing these principles sounded promising. Since then, I've noted an increasing number of those practitioners I respect begin to speak of mindfulness, compassion-based approaches and Acceptance and

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Excerpted from *CBT for Psychosis: Process-orientated Therapies and the Third Wave*

Commitment Therapy. Their enthusiasm left me with the impression of a fresh approach that is a dramatic departure from the rationalisation valued in CBT. Yet despite being around these approaches for a while, when I came to write this chapter my biggest challenge was articulating what these approaches were. After months of staring at a page filled with half-written sentences and a brain left muddled by an array of YouTube lectures and papers on a plethora of 'third wave' approaches, I had to face a worrying truth – I knew nothing. Or, in a less dramatic sense, I knew very little about this third wave and was confused by the little I did know.

There's something about these approaches that can feel intangible and slightly hippy-ish when described in person, yet reads as almost cold and formulaic in academic journals. The combination of scientific sounding theories, clinical terminology and evidence-based practice contrasts sharply against talk of compassion, values and mindfulness. This felt conflict begs the question: Can such approaches really be integrated within a psychology that is concerned with scientific validity, or are they at risk of being subsumed into larger theoretical frameworks that dilute and warp their nature?

As diverse as third wave approaches are, they represent a move away from attending to the specific content of voices, visions and beliefs. When someone is feeling troubled by the content of the voices they hear, a CBT practitioner may feel moved to zoom in and examine the experience in detail – supporting the person to explore, understand and evaluate it in the context of their life experiences. Third wave approaches, rather counter-intuitively, encourage us to zoom out – focusing our attention on the way in which someone relates to, or responds to, their experience rather than getting caught up in the experience itself.

The following threads seem to weave, in different ways, through each third wave approach:

- Acceptance: Being willing to experience the things that we find difficult, rather than seeking to avoid them.
- Mindfulness: Noticing experiences in the present moment, without judging them. Letting experiences drift in and out of one's awareness without trying to hold on to them or push them away.
- Compassion: Based on a Buddhist perspective where one cultivates 'a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it'.

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Rai Waddington

Excerpted from *CBT for Psychosis: Process-orientated Therapies and the Third Wave*

MY EXPERIENCES THROUGH THE 'THIRD WAVE' LENS

To help me get inside the third wave and make sense of its strengths and limitations, I'm going to explore what one approach – Acceptance and Commitment Therapy (ACT) – could offer in terms of understanding, and navigating, some of my own experiences.

THE EXPERIMENT

Walking down the corridors of the ward I felt certain that every move I made was being watched. I knew the staff were keeping notes about me

– but it was more than that. The ward was full of cameras and privacy simply didn't exist. I was admitted there as part of 'the experiment'. I had lived with an alien inside of me since the age of 14. Initially, back home, it was okay. I could feel it growing inside me and influencing my body, yet I could cope. I pulled out my hair and cut myself to wrestle back control. I kept it secret, unsure of how to even begin talking about it.

It was only when I went to university that I began to understand the extent of the problem. As I had moved away from my home, those monitoring the experiment were forced to set up a network of cameras across the campus. They watched every aspect of my life. I could feel their gaze – a prickly sensation on the back of my neck that left me feeling exposed. Then, one day, I heard them talking about me – keeping track of my movements and, at times, ridiculing me amongst themselves. I knew that I could hear them because of an implant in my neck – it felt like a mistake, as if I was listening in on a conversation that I should not be aware of.

The reach of those conducting the experiment was mind-blowing. At home, at university, in town – they could see me no matter where I went. Not only did I feel crushed by their judgements, I felt terrified of where all this was heading. The only respite I got were the times when I went out clubbing with friends – the intoxicating mix of alcohol, rock music and dancing helped to temporarily take my mind off the enormity of what was happening.

Prior to my admission, things began to spiral further out of control. I began to pay more and more attention to the subtle changes in the voices of three men responsible for monitoring me. Their tone sometimes changed in response to what I was doing. I remember walking through the supermarket and, when I reached out for items, noticing that their tone became more foreboding. Walking up and down the aisles, surrounded by people, I tried to determine whether this was their attempt to warn me

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about something or if they were, more worryingly, trying to push me into buying something specific by scaring me away from items that were safe. It was exhausting, and often I left that shop with only a few items

– cheese, milk and orange juice – unable to make eye contact with the checkout staff in case they were in on it too.

My fear of being poisoned increased, so much so that the food-parcels left by my worried parents became a tower of untouched boxes in the corner of my bedsit. I'd long since stopped showering for fear of being seen naked on the cameras. My thoughts raced around my head, fragmented, and I felt completely and utterly powerless. It was at this point my parents came and, with the support of my sisters and friends, moved me back home. It was at this point I went to see a psychiatrist and, with my dad sitting beside me, the events of the last few years began to tumble out of my mouth. The psychiatrist was kind and reassuring, encouraging me to come in to hospital so that they could treat my illness. Of course, I didn't believe I was ill and felt sure it was all part of the experiment I was trapped in. However, for a moment at least, I really wanted it to be true.

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

In stories like mine, it could easily be assumed that the voices and unusual beliefs I struggled with (aka my 'symptoms') were a sign of a deeper problem – an underlying illness. As such, a successful intervention would involve treating the illness, resulting in the reduction or elimination of the symptoms in order to enable me to move forward with my life. An ACT practitioner, however, might be more interested in the way in which I related to my experiences. They might locate the source of my difficulties as a state of 'psychological inflexibility', thinking that I had become entangled with the content of my anomalous experiences and that I was unable to reach my valued goals. They would have had a point; back then I was so occupied with my survival that the idea of any goals beyond this was off the agenda.

An ACT practitioner might also note multiple examples of 'experiential avoidance' in my story – times when I tried to escape from uncomfortable or painful inner experiences. They may have viewed my self-harm as futile attempts to avoid the horrible feeling of having an alien inside me. These actions came with the promise of some semblance of control over an intensely disempowering situation. Similarly, my place of sanctuary (nightclubs) could be seen as a way of avoiding the experience of the voices – literally drowning them out with loud music and dancing. So many of my

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actions during this time could fit inside the experiential avoidance box. From an ACT perspective, our ability as humans to create webs of words and meaning in absence of physical stimuli meant that every time I avoided something I simultaneously re-created it in my head and reinforced it as something truly frightening and powerful. I was stuck in a loop.

When I look back through hindsight's lens this all makes sense. However, I can't shake the feeling that it somehow sidesteps a crucial point – at the time I was not avoiding inner experiences, I was trying to survive real-world harms. When I refused to eat, I was not avoiding the uncomfortable inner experience of feeling that I was being poisoned – I was avoiding being poisoned. My reality was constituted of those experiences outsiders might categorise as 'inner' or 'private'. Within an ACT framework, this might be viewed as evidence of 'cognitive fusion' – that I was responding to my experiences (thoughts, perceptions and beliefs) as if they were unquestioningly true. It could be argued that I became trapped in a web of personal meanings that I then, unknowingly, superimposed on to the world around me; that these meanings prevented me from seeing the world as it really was. My fears became my reality.

Had I seen an ACT practitioner, these are some of the processes we might have worked on together to help increase this psychological flexibility that would hopefully help me identify, and reach, my goals:

- Contacting the present moment: The goal of this process would have been to help me connect with the sensations I experience (mental and physical) in the present moment, noticing them rather than judging or creating stories about them. In an ACT group or session, I might have been taught some mindfulness exercises – beginning with physical sensations and then moving on to noticing my inner states. This is a fundamental skill that I would be encouraged to develop throughout the therapy, hopefully extending it to more worrying or frightening experiences as I learn more about the approach.
- Defusion: The aim of this phase would be for me to have moved away from seeing my voices and beliefs as true, towards being able to notice them as experiences without attaching myself to their content. Within ACT, it's this attachment – a state of cognitive fusion – that can cause problems. The hope would be that by learning the skill of defusion, I would gain enough space to make more flexible choices as to how I respond. Building on the mindfulness skills I would have been introduced to, an ACT practitioner might have encouraged me to play with the idea of there being some separation between myself and the content of my

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experiences through the use of metaphors and practical activities. I might have tried imagining the contents of my mind appearing on a computer screen, or being relayed to me by a chatty co-pilot. I'd have been encouraged to see the extent of information that is given to me during my day and, gently, begin to recognise the possibility of questioning how useful or accurate it is.

- Self-as-context: Rather than defining myself in terms of the content of my thoughts, preferences and beliefs, this process would encourage me to recognise that there is always a part of myself that is noticing that I'm having an experience. Similar to defusion, the aim of developing an awareness of one's self-as-context would be to reduce the tendency for me to get caught up in the immediacy and reality of my experiences. Instead I'd be encouraged to see these things as mental events that are, by their nature, transient.
- Acceptance: In order to help me become free to pursue my goals, ACT would have encouraged me to develop a state of willing acceptance of unwanted or unpleasant experiences. This acceptance would hinge on me beginning to utilise and value those processes that develop space between myself and my experiences. If I was to still believe them to be fully and concretely true, I could imagine that discussions around the futility of my survival strategies would leave me feeling defeated and powerless to escape my fate. Acceptance without defusion feels like a very lonely and sad place to be.
- Values: In this framework, values can be understood as the things which are important to us and add value to our lives. Given the difficulty I had with imagining values outside of survival, a skilled practitioner might help me connect with these through exploration of my fears. The fear of powerlessness and loss of autonomy flow through so many of my experiences, meaning that autonomy and independence were some of the values most important to me at that time. By helping me consider how my attempts to control or avoid my experiences were leading me into situations where control was taken away from me, I would be encouraged to think how acceptance might be a valid alternative.
- Committed Action: This part would involve me choosing specific actions and committing to them, knowing that this involved a willingness to experience difficult things in order to live a life in accordance with my values. It would be about me making choices when I act – living intentionally. In line with my value of autonomy, I might choose a goal like 'cook a meal for a friend'. Such goals are not end points, they are simply tangible enactments of the values that guide our lives.

So, assuming I had successfully completed a course of ACT – where might I be? If I lived these experiences according to an ACT approach I would notice that I was

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hearing voices. I would notice that I had the thought that people were watching me. I would notice that I had a sensation in my neck that felt uncomfortable. I would notice that I was having the thought that someone had placed something in my neck. I would notice a lot of things, and I would notice my uncomfortable-ness with these noticings. However, I would have a little more distance from the intensity of these experiences and, hopefully, enough space to make choices about my responses. Aware of the drawbacks of using experiential avoidance strategies, I would be making a conscious effort to choose to do the things that I'd decided add value to my life. Perhaps, in time, the unwanted experiences might fade – but there would be no guarantee of that, and the acceptance thread might leave me suspicious of the virtues of having that as an aim.

There are parts of this that chime with a path I instinctively carved out to escape the cycle of hospital admissions I got lost in. I chose not to chase my beliefs down the rabbit hole, recognizing that my search for the truth only led me back to the ward. I chose to accept my feelings and resist the urge to untangle or explain them further. Whilst I was more able to keep on track, this path came at a cost. It was exhausting, requiring me to turn my back on my survival instincts and cut myself off from experiences that were literally shouting to be heard. It was ultimately unsustainable. However, noticing my experiences without fully attending to them left me unable to learn from them. I was able to function, more or less, but I felt incomplete. I had erected an artificial barrier to protect me from hospitalisation, yet I had no conception of how to engage with my experiences in a more flexible way. Had I met an ACT therapist at such a vulnerable point in my life I wonder if I would have ever realised that delving into the content of my voices was a valid and useful option.

Things have changed, dramatically, since I looked behind the barrier and began to explore my experiences. I have affection for those three voices that narrate me, and sometimes speak so harshly about myself and those around me. I see them as a reflection of the difficulties I have with groups, having learnt early on that groups of people can be dangerous. I see them as part of my heightened sense of risk-awareness – that they're trying to silence me sometimes in order to keep me safe. I see them, sometimes, as reflections of that insidious type of bullying where your friends speak about you as if you're not there. Most of all, I see them as meaningful and I choose to attend to the content, sometimes, so I can learn from it. I talk with the voices, even though they don't talk back. I see the alien experiment experiences as a canny metaphor for the sense of powerlessness and violation I experienced via childhood abuse (outside of my family). I see it as a reflection of holding a secret that

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I felt none of the people who loved me could ever know – of living in an alternative universe where those adults most trusted by society were the ones causing me harm. Focusing on the content of my experiences, using creativity and peer support, has enabled me to find ways of viewing them that enrich my life.

THE 'NOT YETS'

I am curious to consider how ACT might relate to the 'Not Yets' – a group of violent voices that I still struggle with. How might this compare with my own way of living with such difficult experiences?

A few years ago, I remember lying in bed one morning whilst my husband made coffee. My body felt overwhelmed with unwanted sensations. I could feel people touching me; sharp stabbing pains in sensitive areas. My lips started to tingle and I knew I needed to get out. As I tried to move I realised that my body was frozen to the spot. I could move my head, but nothing else. I heard a woman's voice describing what was going to happen to me – in detail. She called me vile names and I felt like I wanted to vomit. Although it only lasted for minutes, it felt like hours. Afterwards, when my husband returned, I was unable to tell him. I kept it secret for years.

From that day, I began to hear different voices talk about things that left me feeling such intense shame. Some threatened me directly, talking about violent and sexual things that would happen to me. Some spoke as if I wasn't in the room, reciting monotone descriptions of the ways in which people can be hurt; fragmented and repetitive – almost hypnotic in their tone. Some, the ones I find most abhorrent, describe how people around me want to be hurt in very graphic and upsetting ways.

Sometimes these voices are accompanied by body sensations – pain, tingling, burning.

Unsurprisingly, these voices are hard to hear and even harder to talk about with others. In therapy, I grouped them together and named them the 'Not Yets', giving my therapist the clear message that this was a 'no go' area. At times, when I heard them, I would feel consumed with panic. I felt like I was slipping in to another world, a world where I was a bad person who did bad things. At times I felt physically nauseous after hearing them. Even now, they are the most challenging of all the voices I hear – and the ones that I have the most challenging relationship with. Even writing about them in this chapter feels like a huge risk.

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ACT AND THE 'NOT YETS'

One of the hardest challenges I might face in ACT would be developing a willingness to experience unwanted and torturous painful physical sensations, and those voices that tell me to hurt the ones I love. The other would be the sad fact that I would be unlikely to ever bring these experiences to therapy. Saturated with shame, it is hard to imagine building the degree of trust needed to offer these experiences as examples to work with in a time-limited therapy.

Yet, in my own way, I have come to accept their existence. The distance I have found comes from framing my experiences as an echo of something I don't yet understand. Whenever I have a painful physical experience, I tend to my body when needed (often using massage) and remind myself that this is an echo of something that hurt. I (sometimes) talk to my younger voices inside and remind them that I'm there and that – in the now – they are safe. I might surround myself in a blanket, or cuddle a fluffy owl. Ultimately, I wait for it to pass.

The 'Not Yets' speak to me with such certainty and power that I can find myself flinching. The idea of listening to them is difficult and I have found all kinds of ways to avoid this. Whereas ACT may encourage me to distance myself from their difficult content – casting them as a thought and simply noticing their presence – the most progress I have ever made with these voices came from getting uncomfortably close. Counterintuitively, the 'Talking with Voices' approach facilitated the creation of a completely different kind of space. By allowing one of the voices to speak with a practitioner, a trusted colleague, I had the opportunity to hear the voice in a new way. More than that, I heard another person respond to it with firm compassion and curiosity. I felt its hesitation, its lack of connection. The transformation this engendered in me is hard to verbalise, but I left that session with a deep sense of sadness for this voice that cannot yet connect. I began to see it as stuck in a role it does not know how to get out of.

This depth of engagement with this difficult voice held more transformative potential than simply letting it pass me by, as if it was a passenger on my bus. By letting the voice take the wheel for a while I was able to take part in a kind of experiential learning that is slowly changing how open I feel I can be to that particular experience. This experience leaves me wondering if ACT's emphasis on defusion may be missing a trick. After all, do I really need to see my experiences as verbal events/thoughts in order to become more flexible in my responses? My voices are real. They are part of my reality. Defusion is only one way of relating to experiences in a vast array of

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possibilities. Compassion is another. Neither, in and of itself, is a goal nor a symbol of success. In my journey these ways of being have emerged as consequences of a larger and more meaningful changing relationship to myself, the world and my experiences. It feels almost nonsensical to package these as a desirable skillset, as if we are focusing on a specific detail but missing the bigger picture.

CRITIQUE OF ACT AND OTHER THIRD WAVE APPROACHES

So, whilst there is much about ACT and its brethren that I appreciate – and some of its techniques echo things I have found helpful in my own journey – I am left with a number of concerns.

CBT'S EVER-GROWING UMBRELLA

When first preparing this chapter I was rendered almost motionless by the array of approaches that can be termed 'third wave CBT'. Whilst they are linked by some obvious themes and values, their theoretical underpinnings and practice are diverse. Both ACT and Compassion-Focused Therapy (CFT), for example, encourage people to connect with difficult experiences rather than attempt to avoid them – teaching mindfulness and utilizing experiential exercise to facilitate this. However, when one looks underneath the hood it is clear that they are based on radically different theories. Whereas ACT was derived from Relational Frame Theory and is thus concerned with promoting psychological flexibility, proponents of CFT cite neuroscientific insights into affect-systems as underpinning their practice. It is this understanding that drives CFT's focus on developing people's ability to access or activate their soothing systems, enabling them to be kind and compassionate with themselves.

If the roots of these two approaches are so different, why gather them together under the same umbrella? It's at this point a cynical part of me raises its hand and wonders if the link is the identity of the CBT practitioners who champion them, not attributes of the therapies themselves. I could imagine that trained CBT practitioners each developed their practice using ideas from other fields and cultures, weaving them into their work to address growing concerns about the neglect of emotional life and prioritisation of the rational in second wave CBT. An even more cynical part of me is curious about whether ACT, CFT and the other approaches sheltering under the third wave umbrella would have their current place in mental health services if they were not considered a development of an already accepted treatment approach (CBTp). Whilst there is a growing evidence base for these approaches, does their conceptualisation as a 'third wave' provide a veil of acceptability that lessens the

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likelihood of them being relegated to the fringes? Is there a strength in numbers that would be lost if we spoke about them in isolation?

If this is the case, I am mostly glad that these approaches are becoming more accepted or credible through their association with CBTp. However, it does bring with it the concern that CBTp is crowding out the wider range of psycho- therapies and social support options available in our so-called evidence-based and under-funded mental health services. In growing like a town that absorbs its surrounding villages, CBTp leaves little room for innovation and approaches that are messier or less easily evidenced. I've found it increasingly hard to argue for the development of Hearing Voices Groups within services that view time-limited ACT for Psychosis groups as a good value evidence-based option. How many Early Intervention in Psychosis services encourage longer-term psychotherapy when they have limited resources and guidelines that necessitate the provision of CBTp? In an ideal world this competition would not exist, with services being sufficiently resourced to offer a menu of need-adapted options. Yet we live in a world where one therapy can squeeze out others and, albeit unintentionally, the growing third wave umbrella could hasten this. In stretching to include elements of other approaches, third wave CBTp risks becoming the psychotherapeutic equivalent of an all-you-can-eat buffet; a cheap but not particularly tasty alternative to choosing a specific cuisine.

MISAPPROPRIATION OR A MELTING POT?

Many of the principles now core to these approaches are ones that I have learnt through discussions with voice hearers and other survivors in the Hearing Voices Movement – long before they became psychological therapies. My own journey of healing, described above, is peppered with practices that can be found in both ACT and CFT. I came to these outside of formal therapy, in conversations with other people with lived experience and through our collective knowledge base. Are these similarities a coincidence, developing independently, or has there been some cross-fertilisation? The answer to this question is, in many ways, unimportant – they are useful approaches and their spread within mental health services can help many in distress. The current context of mental health provision is challenging enough without engaging in turf wars with allies, fighting to own the provenance of a particular idea of technique. However, the potential for survivor expertise to be colonised by the psychological disciplines cuts me deeply.

This is not an idle worry. I regularly hear psychologists (and other mental health professionals) remark that my way of working with voices – developed through the

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Hearing Voices Movement – is similar to ACT, CFT, psychological formulation, psychodynamic, or whatever approach floats their particular boat. I get the feeling that these words are intended as gifts, appreciative and validating. I imagine that, sometimes, they can be peppered with a wish to gain a similar gift from me – the recognition that they are already working in a way that values lived experience.

However, my experience of these moments is that they steal survivor expertise by recasting it as a diluted form of professional expertise. It feels a little like an adult patting a child on the head when they play dress-up and mimic adult chores. In our society, professional expertise has the power to drown out those survivors. History, as they say, is written by the victors. This is not inevitable, yet its navigation requires a great deal of reflection coupled with an awareness of power and privilege.

A MISSED OPPORTUNITY FOR LEARNING

In its focus on the way we relate to our thoughts and experiences, rather than the experience themselves, third wave approaches may leave little space for exploration and understanding. Yet it is this sense of curiosity and a willingness to engage with the content of my experiences in some creative and unconventional ways that has been so fruitful in my own life. I've found the use of art to communicate with voices rather than simply express them, for example, to provide fertile soil for beginning to dialogue in a more traditional sense. Exploring the different potentials for relating to the voices I live with, and the ways in which they can relate to each other, using characters from graphic novels, has opened up new possibilities for collaboration.

The ability to be able to distance myself from my experiences has been crucial, but it was only one step amongst many. In a culture of short-term therapy, I wonder what can realistically be achieved in six, twelve or twenty-four sessions. I wonder whether practitioners have the chance to encourage curiosity about the content of experiences, or whether they feel the need to keep things simple and limit their aim to one of mindful acceptance. There is a danger that in promoting a sense of detachment from one's voices and thoughts, practitioners could communicate an implicit message that engagement with the voices is therefore 'bad'. Such a message could, combined with distressing voice-content, leave someone hearing voices for years but never really listening to them. Whilst this is a step up from a sole focus on suppressing voices (which can carry the implicit message that voices and beliefs are so powerful and dangerous that they can only be caged by equally powerful drugs), it is a long way from the careful engagement that has helped me reclaim my past, present and future.

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MAINTAINING THE EXPERT POSITION AND PROPPING UP THE STATUS QUO

Whilst looking at YouTube videos on third wave approaches, I was shocked at some of the overtly medical language and assumptions used to describe those of us who struggle with voices, unusual beliefs and other experiences labelled as psychosis. In side-stepping engagement with the content of people's experiences, there is a risk that the third wave is also side-stepping debates on the meaningfulness of our experiences and the deep insult that is labelling people as 'severely and enduringly mentally ill'. With a pragmatic focus on people's quality of life, third wave approaches may be part of maintaining the status quo and leaving people forever cast as patients who simply need to have a different relationship to their so-called symptoms. Where is the potential for revolution?

The therapist role can be cast as the one of expert, there to teach the patient a healthier way of thinking to effect change. Whilst this can be enacted in a compassionate and supportive manner, the kindness of the therapist does not erase the potential for such therapies to replicate the power imbalances found in mainstream mental health services. With successful therapy contingent, in part, on the patient adopting the therapist's way of thinking about difficult experiences, the client's voice may be silenced if they intuit that their existing framework is not welcome nor valued in the space.

Are people encouraged to consider the social causes of their distress, and to gather together to change it? Are issues of class, gender, race, prejudice, poverty, sexuality, disability and other social inequalities attended to? Whilst these are blind spots of many therapies, the third wave emphasis on acceptance can make these issues particularly problematic. Changing the way I feel about my experience of injustice may help me feel better in the short-term, but without the fire in my belly it provokes I may lose the drive I need to fight against it. Moreover, this way of thinking about experiences may promote the individualisation of societal problems. If we have a therapy that eases experiences of injustice and helps people accept their lot, why bother spending money on addressing structural inequalities and preventing childhood abuse? Just as mindfulness in Buddhism is connected with a strong ethical framework, third wave practitioners need a firm commitment to human rights and social justice to help guide their work. What happens inside the therapy room is deeply connected to our wider social and political worlds.

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THE IMPOSITION OF WAYS OF THINKING AND BEING IN THE WORLD

Third wave approaches are particularly intriguing to me as they seem to teach particular ways of thinking about our experiences, our selves, and what constitutes wellbeing. They go beyond tools used by therapists to aid exploration to become a set of skills and principles to implement, on which one's health is supposedly contingent. In ACT a combination of acceptance of distressing experiences, detachment from these experiences and a commitment to acting in accordance with one's values is prioritised. In Compassion-Focused Therapy, the emphasis is on developing the ability to sit with one's distress and feel compassion for oneself. These are all valid paths through distress, yet they represent a mere fragment of the many ways people can 'be' in this world.

> ACT clients are encouraged to abandon any interest in the literal truth of their own thoughts or evaluations; instead, they are encouraged to embrace a passionate and ongoing interest in how to live according to their values.
>
> – Hayes (2004)

If someone feels overwhelmed with experiences that they cannot avoid, the idea of teaching people different ways of relating to these feels helpful. However, if we teach one path in isolation and disregard other possibilities we risk preventing people finding a way forward that is uniquely suited to them. We might impose frameworks that are culturally or spiritually loaded, chock full of assumptions that might not chime for those we try to squeeze into them. There is a potential for these approaches to convey a moral stance towards ways in which we 'should' relate to our experiences, with some clients learning that engagement with experiences is unenlightened or 'bad'. Are these approaches really as benign as they sound?

Given that these approaches each teach different ways of thinking about experiences that go beyond exploration, I would argue that it is crucially important for potential clients to make an informed choice about which approach they wish to try. However, in modern mental health services such a choice is rare indeed. People are lucky if they get offered CBTp, and the particular third wave approach they encounter will often depend on the preference of the practitioner they are allocated to. This is an issue for counselling or psychotherapy in general – clients rarely get a choice over the specific modality of the therapist. However, in more exploratory approaches the modality shapes the way in which the therapist interacts with, and understands, the client – not a particular way of being that the client is encouraged to adopt.

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In an ideal world, I could imagine a potential client having multiple taster sessions to try out different therapies. I imagine the role of a therapy broker whose role is to aid informed choice, demystifying different approaches and transparently setting out their particular assumptions, values and goals. I imagine a potential client receiving the message that these are simply different paths we can take on our journey, rather than the holy grail of healing. Of course, this would involve the widespread availability of a multitude of approaches – short and long-term. Whilst I think this is something we should fight for, in the meantime the responsibility sits with individual practitioners and teams to conduct themselves in as reflective and ethical a way as possible. By keeping up-to-date with some of the many alternative ways of working with distressing experiences, practitioners may be better able to resist the temptation to mentally stick to a single approach as the 'answer'. By supporting alternatives such as Hearing Voices Groups, Talking with Voices or the creative therapies, practitioners can help to widen out the space in psychological services. Rather than be content with psychological, social and psychotherapeutic approaches fighting for scraps from the biomedical table, let's work together to embed them at the heart of mental health care.

WHERE CAN WE GO FROM HERE?

The drive for therapeutic interventions to be grounded in scientifically tested models feels like an artefact of the push for clinical psychologists to be defined as scientific practitioners – of the boundary-keeping of a profession that is hard to differentiate from its brethren. It feels as if psychological therapies are being boxed into a corner, competing against biological treatments that are backed up by multiple RCTs that appear to support their places as the cornerstone of treatment, despite significant concerns around their efficacy and long-term safety. Psychological and psychotherapeutic work is not, to me, a prescription we can take. Attempts to compare it like for like risk missing the creativity and fluidity of therapy that I value so deeply. I do not want to adhere to a particular model of thought. I want the flexibility to integrate some of the ideas, practices and skills found in third wave approaches as if they're on a buffet table in front of me and have the freedom to customise a meal that suits my needs. As a client and practitioner, I want choice not dogma.

I want to try some ACT, but I don't want a focus on living in line with my personal goals and values – that feels like a lot of pressure. I want to use mindfulness, but I don't want to lose my intensity and depth of connection with my experiences. I want to be compassionate, but I also want to draw a line in the sand and feel okay to be

A STEP IN THE RIGHT DIRECTION OR A MISSED OPPORTUNITY?

Rai Waddington

Excerpted from *CBT for Psychosis: Process-orientated Therapies and the Third Wave*

angry. This anger can be a fire that drives me. I can use it. I do not want to be detached and accepting. I want to learn from my voices as teachers – even the ones that tell me to hurt people (I just want to listen to them in a way that means I can make choices about how I interpret them).

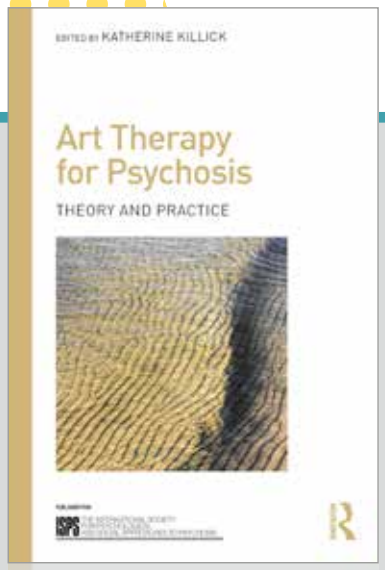
Most of all, I long for approaches that can balance the teaching of skills and techniques with an exploratory attitude that does not define what is – or isn't – important to attend to. I imagine psychologists and other practitioners becoming trusted guides whose focus is on helping the person in distress find their own path through the messiness of being human. I long for the use of tools without a grounding wider theory, adapting around the person. I want to rip up the protocols that can provide practitioners with a sense of stability, and exchange them for a focus on connecting with people where they are at . . . and increasing the trainee's ability to tolerate 'not knowing' and, perhaps, even to embrace it. Ultimately, I want psychological, social and spiritual approaches to take up a bigger space in our mental health systems. I want this space to be as pluralistic as possible, so we don't simply swap narrow biological responses for narrow psychological ones. This is a time for choice.

CHAPTER

5

INTRODUCTION: PLACES FOR THE MIND TO HEAL

Katherine Killick



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INTRODUCTION: PLACES FOR THE MIND TO HEAL

Katherine Killick

Excerpted from *Art Therapy for Psychosis*

The title of this Introduction refers to the final paragraph of a chapter I contributed to the book *The Changing Shape of Art Therapy* (Gilroy and Mcneilly 2000) in which I quoted a person who had spent many years as a patient in art therapy and who had sustained a commitment to working with me over years of multiple inpatient admissions—including some to the locked ward in the hospital, day hospital attendance, and outpatient treatment. The words 'people like me need places like that art room—places that allow the mind to heal' were part of the patient's expression of gratitude in our final session (Killick 2000). This book bears witness to the meaning and relevance of 'places like that art room' for people who, like my patient, experience psychosis.

The eight chapters in this book can each be read as an individual 'standalone' essay. The book as a whole aims to develop the reader's understanding of the appropriateness of art therapy as a treatment medium, both for people in acute psychotic states and for those who historically have a proneness to psychosis. it presents innovative theoretical and clinical approaches that were developed in a range of different treatment settings in Denmark, Finland, Italy, the UK, and the USA, and some of the chapters use illustrated case material to amplify the reader's understanding of the complexities of this subject. The diverse approaches in theory and in practice that the book's eight chapters present offer the reader common understandings of the key issues involved in working with people who are prone to psychosis, and of the potentials of specialised forms of art therapy in bringing about fundamental and lasting psychological healing.

The specialised field of art therapy as a psychotherapeutic treatment approach to psychotic states of mind has matured since the publication of the book that Joy Schaverien and I co-edited in 1997, *Art, Psychotherapy and Psychosis*. At that time, there was a need for a book to define this field of clinical practice within the art therapy profession, and to introduce the approaches that had developed at that stage. This book continues that process, presenting a range of theoretical and technical approaches that evolved within the field over the ensuing twenty years in different clinical settings and in different countries. Its presence in the ISPS series is in itself a sign of the increased recognition that the field of art therapy for psychosis has earned over the years. It is my hope that this book will offer its reader an understanding of the specific potentials that art therapy offers to people experiencing the ravages of psychosis, and that it will provide the basis for further research into this subject.

In my opinion, one of the most significant developments in the field since 1997 was the ground-breaking research undertaken over a number of years by Goldsmiths

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Katherine Killick

Excerpted from *Art Therapy for Psychosis*

College, University of London and Oxleas NHS trust, which developed an evidence-based 'clinical practice guideline' (Brooker et al. 2007) for art therapists to refer to when working with people prone to psychosis. This collected all the existing published work on the subject and distilled the understanding of expert specialist practitioners and the experiences of service users, identifying the adaptations of art psychotherapy technique that are most significant when working with people who are prone to psychosis. Many of those findings resonate with the approaches presented in this book, and to date, as far as I know, there have been no clinical trials of art therapy in which the research design was informed by these key issues that emerge as specific to art therapy for psychosis. Accordingly, the effectiveness of art therapy as a treatment approach remains a matter of opinion.

The theoretical basis of the work that I and other practitioners presented in *Art, Psychotherapy and Psychosis* (Killick and Schaverien 1997) was predominantly informed by various traditions within psychoanalytic thinking, which prevailed within the profession at that time in the UK. However, the chapters by Maclagan, Wood and Henzell reminded the reader that art therapy evolved from, and is informed by, a diverse background of theoretical and philosophical traditions, within which psychoanalytic theory and practice is one element amongst many. This is reiterated by the diversity of theoretical and philosophical approaches that underpin the various chapters in this book. These include original perspectives derived from neurophysiology (Lehtonen and Peciccia and Donnari), phenomenology (Teglbjaerg), ontology (Bonneau) and cognitive analytic theory (Rankanen), as well as those derived from different psychoanalytic traditions. In Chapter Five, Cohen introduces the reader to Lacanian psychoanalysis and to the unique perspectives that this offers to thinking about psychosis and working with psychosis in art therapy. Chapters Two (Peciccia and Donnari), Four (Bonneau), Six (Greenwood) and Eight (Hagert) include thinking derived from Freudian and Kleinian schools of psychoanalysis. In Chapter Six, Greenwood introduces the concept of *mentalisation* that has evolved within current psychoanalytic thinking, and applies the concept to art therapy theory and practice.

Some of the chapters in the book are written from the perspective of the therapist, whereas others include reflections from patients. The chapters written by Teglbjaerg (Chapter Three), who introduces artwork-focused art therapy, and Rankanen (Chapter Seven), who introduces dialogical art therapy, each include material contributed by the authors' patients about the meaning and relevance of the art therapy process described. The necessity for patients to provide informed consent for the use of their material in this book, and the effect that seeking consent could have

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on the therapeutic relationship, has been managed by different authors in different ways. Bonneau (Chapter Four), Cohen (Chapter Five) and Greenwood (Chapter Six) make use of imaginary 'vignettes' based on, but not descriptive of, the authors' clinical experiences to illustrate the approaches being described, whereas Peciccia and Donnari (Chapter Two), Rankanen (Chapter Seven), and Hagert (Chapter Eight) sought consent from patients for the therapist to present images made by their patients, and verbatim accounts of therapeutic interactions. the detailed, illustrated case studies presented in Chapters Two (Pecicia and Donnari), Seven (Rankanen), and Eight (Hagert) vividly convey experiences that are characteristic of art therapy process with people in psychotic states of mind in different settings.

Each chapter presents aspects of what is involved in working in art therapy, both individually and in groups, with people experiencing the vulnerabilities deriving from psychosis. The nature of psychosis is considered in each chapter, and by implication, theories of primitive, pre-verbal states of mind. Common understandings of the profound anxieties pervading these states of mind, and of their role in psychotic states, emerge from different theoretical perspectives. These understandings form a basis for appreciating the traumatic threat that the relationship with the therapist presents, and, accordingly, this threat is taken into account in the therapist's approach.

The chapters present a range of different approaches, through which common understandings of the role that art-making can play in psychotherapeutic work with psychosis emerge. Both individual and group treatment settings are considered. Chapters Four (Bonneau), Seven (Rankanen) and Eight (Hagert) focus on work with individuals, whereas Chapter Three (Teglbjaerg) focusses on work with groups. Chapters Two (Peciccia and Donnari) and Six (Greenwood) discuss the use of the approaches presented in the chapters in both individual and group settings.

Throughout the book, art-making and transactions surrounding the making of images and the presence of art objects form a field of experience within the therapeutic relationship that is considered from the different theoretical perspectives presented to be of specific value when working with psychosis. Lehtonen (Chapter One) and Teglbjaerg (Chapter Three) both present rigorously researched arguments identifying art-making as a healing agent in psychotic states when this takes place within a specialised therapeutic relationship. This resonates with the approach that the pioneer of art therapy for psychosis in the UK, Edward Adamson, developed in his work at Netherne Hospital, described in his seminal book, *Art as Healing* (1984), which placed emphasis on the art-making process as healing in itself. Lehtonen presents this argument in relation to an original neuroscientific and developmental

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theory of mind and of psychosis, and Teglbjaerg presents it from the perspective of phenomenology, introducing the reader to the original form of art therapy practice that she has developed, named 'artwork-focused art therapy'. Peciccia and Donnari (Chapter Two) extend the concept of art-making to include ways of working with images that are facilitated by modern technologies.

The book as a whole identifies issues that need to be considered when developing therapeutic relations with people prone to psychosis if the therapeutic potentials of art-making and of other elements within the art therapy setting are to be maximised. To a greater or lesser extent, all the chapters discuss the fragmentation of the sense of the experienced, embodied self and the breakdown in the capacity to use words as symbols as aspects of psychotic states that necessitate specialised therapeutic approaches. The concepts presented by Peciccia and Donnari (Chapter Two), Bonneau (Chapter Four) and Cohen (Chapter Five), which are drawn from Freudian, Kleinian, Lacanian and existential schools of psychoanalysis, lay theoretical foundations for understanding the way the therapist may be experienced by the patient when mediating the experiences of symbolic realities that cannot be engaged with in psychotic states of mind. Teglbjaerg's phenomenologically based approach (Chapter Three) and Rankanen's cognitive-analytic approach (Chapter Seven) contribute similar understandings from very different philosophical and theoretical traditions.

The potential for the balance of institutional power to exacerbate the suffering of the patient emerges in several chapters and is discussed in depth from different perspectives by Cohen (Chapter Five) and Greenwood (Chapter Six), who also draw the reader's attention to the significance of the power differential within the art therapy setting and the necessity for attending to its effect on the therapeutic relationship. some of these issues are highlighted in Chapter Eight (Hagert), which discusses the particular challenges and complexities of psychotherapeutic work with people in psychotic states within 'correctional' settings.

The need for a specifically structured psychotherapeutic relationship that respects and accommodates the extreme anxiety that lies at the core of psychotic states formed the subject of my own published work (Killick 1991, 1993, 1997, 2000), and this is described and discussed in some detail by Bonneau (Chapter Four), who demonstrates the adaptation of the principles of my approach to a setting more characteristic of present-day art therapy practice. The vignettes presented by Bonneau illustrate the issues involved in engaging with psychosis and establishing therapeutic relations within the art therapy setting. At this early stage, the psychotic

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patient's use of imagery and setting is often primarily self-protective. The therapist's understanding and acceptance of the patient's profound anxiety, and of the consequent use of the setting for self-protection, enables a particular form of primitive therapeutic alliance to develop. This exerts no pressure on the patient to engage prematurely in symbolic ways of relating, but it maintains a constant invitation to do so if and when he or she is able and willing.

The different approaches presented in the book all make use of specific potentials of the art therapy setting to protect the patient's fragile sense of self, whereas the unintrusive yet consistent presence and attitude of the therapist maintains the possibility of engaging in an interpersonal relationship. The detailed, illustrated case study in Chapter Two (Peciccia and Donnari) illustrates the way in which a psychotic patient's sense of self can gradually strengthen through repeated experience of the art therapy setting, to the point where he or she may dare to risk engaging affectively with the therapist. At this point, the images can begin to serve communicative purposes and, accordingly, to develop the potential to be used as symbols. the case study presented by Rankanen (Chapter Seven) includes the dimension of relatedness that becomes possible when patient and therapist engage in reflective discussion in relation to images that have acquired symbolic meaning within the relationship. At this point, the patient can potentially engage in forms of art psychotherapy that rely on the capacity to use words as symbols, as well as in other forms of psychotherapy that do so.

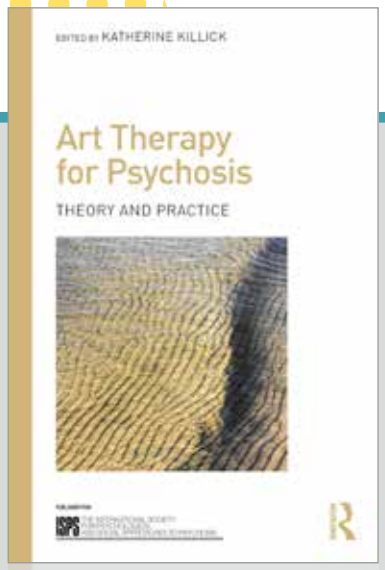
The specific value of art therapy for psychosis as presented in this book lies in its capacity to offer structured psychotherapeutic approaches that minimise the requirement for forms of interpersonal relating that are to a greater or lesser extent impossible in psychotic states. The various approaches presented in the chapters reveal ways in which art-making in itself can become a healing agent, and in which the interpersonal context within which this happens can become another. The presence of art objects in the setting and the transactions surrounding the making of images and their presence can be employed by the therapist to form therapeutic alliances with people in psychotic states, and to undertake work by means of which fundamental change is possible. Returning to the memory of my patient's words, quoted at the start of this piece of writing, it is my hope that individually and collectively the chapters in this book demonstrate that 'places' that enable 'the mind to heal' can be developed within a diverse range of treatment settings. They evolve through the particular forms of relatedness that can develop between therapist and patient in specialised forms of art therapy, and they rely on the therapist's appreciation of and respect for the particular form of suffering experienced in psychosis.

CHAPTER

6

PSYCHODYNAMIC ART THERAPY FOR PSYCHOSES

Peciccia and Donnari



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PSYCHODYNAMIC ART THERAPY FOR PSYCHOSES

Peciccia and Donnari

Excerpted from *Art Therapy for Psychosis*

INTRODUCTION

In this chapter, we discuss the fragmenting effect of psychotic defences on verbal language and on dreaming, which presents a major obstacle to analytical verbal psychotherapy with people in psychotic states of mind. We propose that psychotic patients are in need of an inter-subjective experience where they can draw and 'dream' with a therapist, and we present the progressive Mirror drawing technique developed by Peciccia and Benedetti as means of establishing experiences of this kind. The potentials of new technologies have amplified the range of 'dreaming' experiences that are available to the therapist, and developments of the technique by Peciccia and Donnari, making use of these potentials, are described.

Many psychoanalysts working with psychotic patients, among whom are Abraham (1908), Freud (1924), Federn (1929), Bion (1957), Benedetti (1991), have presented the fragmentation of the experience of the self in relation to inner and outer reality in psychosis, and have seen a consequence of this as a difficulty for people experiencing psychosis to dream in the normal sense of the word. Bion (1962) wrote that the person suffering, incapable of dreaming, remains suspended in a state where he/she 'cannot go to sleep and cannot wake up'. He introduced the concept of 'alpha function' to psychoanalytic thinking to describe '... the unknown process involved in taking raw sense data and generating out of it mental contents which have meaning, and can be used for thinking.' (Hinshelwood 1991). His paper 'differentiation of the psychotic from the non-psychotic personalities' (1957) differentiated the nature of fragmented states of mind characterised by the failure of alpha function, and those characterised by the presence of alpha function, such as dreaming. We propose that the psychotherapeutic approach that we introduce, which we call 'progressive mirror drawing,' enables the evolution of alpha function in states of psychotic fragmentation.

Progressive mirror drawing is based on the psychodynamic theory that connects the fragmentation of the primary process and dreamwork of people in psychotic states to a split between two states of the self. Peciccia and Benedetti (1996) define these split states as 'separate' and 'symbiotic'. We speculate that split states are correlated, at a neurophysiological level, to those neural circuits responsible for self-other identification (the putative mirror neuron system) and those responsible for self-other distinction (multisensory integration circuits). The approach aims at therapist and patient 'dreaming out together'. Racamier (1976), like the other psychoanalysts mentioned previously, pointed out the difficulty of dreaming, in the usual sense of the word, in psychotic states. He considered delusions to be an external 'dream' that realised the content of the undreamed internal dream in outer reality, and called

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them 'dreaming out'. In progressive mirror drawing the images are 'dreamed together' because patient and therapist move, displace and condense them outside, on the paper, using classical psychoanalytic dream mechanisms (Freud 1900).

We compare the 'progressive mirror drawing' approach to Winnicott's Squiggle game. The concept of the 'transitional subject' introduced by Gaetano Benedetti (1988), which is a key concept of the method, is discussed in relation to the concept of the 'analytic third', presented in the work of Ogden (1994). The transitional subject, co-constructed by the patient and the therapist, leads the healing process through dreams, images and drawings. These productions belong to the couple but are also a 'third'. That is, they have an independence from both the therapist and the patient. The therapeutic images co-created in the transitional subject are placed in new associative sequences with symbolic connections that, in our opinion, can repair the associative links and networks that are fragmented by psychosis. These associative threads, made of images and emotions, eventually constitute a viable alternative to delusion, which can be understood to originate in a vain attempt to repair the tear between the ego and reality.

We demonstrate the therapeutic approach and the potential of the method by presenting a clinical case study. The chapter concludes with a description of different audiovisual technological applications that can amplify the sensory integration that is typical of progressive mirror drawing. These innovations allow us to glimpse the possible future development of progressive mirror drawing and PaINTeraction system in the psychotherapy of psychosis.

THE TRANSITIONAL SUBJECT

Peciccia and Benedetti (1992) propose that transitional subjects emerge in the drawings created in the progressive mirror drawing approach. These derive from the unconscious of the two partners and represent the patient's and the therapist's selves. They have the dual function of transmitting to the self both positive and negative affects and, at the same time, of protecting the patient's self from the disintegrating and disorganising action of emotions. Benedetti (1991) wrote:

> The term transitional subject is connected, to both Winnicott's transitional object and to Kohut's self-object. Using this term, however, I describe phenomena that are not limited to childhood but occur strongly at a level which is completely unconscious, to the point of inducing, simultaneously, in the therapist and in the

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> patient, the rise of what I call twin dreams.
>
> – Benedetti (1991: 281)

The transitional subject is an inter-subjective figure that is created in the common unconscious of the analytic couple and 'has roots both in the person of the analyst and the patient and completes the analytic duo with a figure of triangulation' (Benedetti 1991: 209). It is 'a figure that combines the two aspects of patient and analyst … which can also be a visual projection of the patient, a hallucinated voice, a production of delusion, a work of art, but also an analyst's dream or fantasy … The transitional subject, which sometimes acts independently of the therapist and the patient, is therefore the third subject, next to the patient and the analyst.' (Benedetti 1991: 110–111).

The theory concerning the transitional subject that was formulated by Benedetti at the end of the 1980s and in the early 1990s (Benedetti 1988; Benedetti and Peciccia 1989; Benedetti 1991) is very similar to Ogden's descriptions of the 'intersubjective analytic third', simply called 'the third analytic subject' or 'the analytic third' (Ogden 1994):

> The analytic third is a concept that has become for me in the course of the past decade an indispensable part of the theory and technique that I rely on in every analytic session.
>
> – Ogden (2004a: 167)

> The analytic situation, as I conceive of it, is comprised of three subjects in unconscious conversation with one another: the patient and analyst as separate subjects, and the intersubjective "analytic third" … a subject jointly, but asymmetrically constructed by the analytic pair.
>
> – Ogden (2004b: 863)

> Because the analyst's experience in and of the analytic third is predominantly unconscious, he must make use of indirect methods to gain greater conscious access to this aspect of the analytic relationship. The analyst's exploration of his reverie experience represents one such indirect method.
>
> – Ogden (1997: 161)

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> The analyst's dreams (his reveries in the analytic situation) are from the outset neither solely his own nor those of the patient, but the dreams of an unconscious third subject who is both and neither patient and analyst.
>
> – Ogden (2004b: 862)

Benedetti, like Ogden, thinks that the experience and awareness of the transitional subject in both the patient and the analyst are different and asymmetric. In conditions which are optimal for the psychotherapy of psychosis the most significant difference, defined by Peciccia and Benedetti (1996), is that the analyst has a symbiotic self which is integrated with his separate self, whereas, in the patient, these two self-states are split.

In these cases of splitting of the self, the transitional subject can manifest itself through hallucinations or delusions. Benedetti (1992) wrote:

> Often the transitional subject is perceived, by the psychotic patient, as an extra-psychic phenomenon, such as a voice, a hallucination, which still bears all the traits of a psychopathological third reality between patient and therapist, but, unlike the usual psychopathological phenomena, is already offering a healing process … This voice provides the patient with interpretations that are sometimes even better than those that come to mind to the therapist.
>
> – Benedetti (1992: 79)

Both Benedetti and Ogden reported cases in which the transitional subject and the analytic third are also experienced in an extra-psychic space by the analyst as auditory hallucinations (Benedetti 1991) or somatic delusions (Ogden 1994). According to Benedetti, the transitional subject manifests itself not only through hallucinations or progressive delusions but also through daydreams, therapeutic dreams, associations, fantasies and drawings (Benedetti 1991). Benedetti's 'transitional subject' and Ogden's 'analytic third subject' are the protagonists of the field shared by the analytic couple, dreaming and drawing in the dual dimension in which the patient alone cannot dream and draw. The analyst makes the patient aware of the co-belonging, of the transitional subjects and of the mirror drawings, to the analytic couple, stressing their transforming and therapeutic role in the shared field. We propose that from this common ground the patient can absorb the ability to draw and to dream, i.e. the ability to oscillate between symbiosis and separation.

PSYCHODYNAMIC ART THERAPY FOR PSYCHOSES

Peciccia and Donnari

Excerpted from *Art Therapy for Psychosis*

THE SYMBIOTIC SELF AND THE SEPARATE SELF

Benedetti and Peciccia (1996) have hypothesised that the sense of identity of many people experiencing psychosis is threatened by a profound conflict between two states of the self that are characterised by opposing and highly intensive needs. In the same person, an extreme need to merge self and other can co-exist with the need to radically separate the subject and the object. These distinct aspects of the self can cooperate, be in conflict, or even attempt to destroy one another. Other authors, such as Stern (1985), Solan (1991), Mentzos (1991) and Ogden (1992), have described the coexistence in humans of different states of the self pushing towards union as well as towards separation. Benedetti and Peciccia referred to the psychic state that differentiates the self from objects as the 'separate self' while referring to the state that unites and blends the self with objects as the 'symbiotic self'. They think that these different states of the self are present in everyone, with varying degrees of integration. In some psychotic people, they are split to such an extent as to make cohesion and unity of the self fragile or impossible (Peciccia and Benedetti 1996). Neurophysiological research on the brain circuits responsible for self-other identification (the putative mirror neuron system) and those responsible for self-other distinction (multisensory integration circuits) offers an interesting neural basis for Benedetti and Peciccia's psychodynamic understanding of psychosis as lack of integration between the symbiotic and separate selves.

Gallese (2003) suggests that in psychosis a lack of integration occurs between an identity promoting social union (which he refers to as social identity or social self) and an identity (which he refers to as individual identity or individual self) based on self-object distinction. He put forward the hypothesis that the mirror neuron system could be the neural basis of the social self that promotes union (Gallese 2003; gallese and Ebisch 2013) whereas the multisensory integration circuits (involving many cortical and subcortical brain areas such as the ventral posterior premotor cortex and the posterior insula cortex) could be the neural underpinning of a bodily material sense of self which forms the individual identity (Gallese and Ebisch 2013). Functional alterations of neural circuits responsible for self-other identification and self-other distinction had been previously demonstrated in psychosis. In a recent review, Metha *et al*. (2014) described several studies in which patients diagnosed with schizophrenia showed mirror neuron system dysfunctions. Alterations involving the multisensory integration circuits had been reported by Ebisch *et al*. (2013). Furthermore, an fMRI study on 24 patients with a diagnosis of schizophrenia illustrated abnormal connections between shared brain circuits of self-other identification and the

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multisensory circuits of self-other distinction (Ebisch *et al*. 2013). These neurophysiological studies confirm the data presented by several authors who describe alterations of sensory integration in people with a diagnosis of psychosis (for a review of the subject see Velasquez *et al*. 2011 and Postmes *et al*. 2014).

In the last thirty years, many researchers have been investigating sensory integration therapies for psychotic people (King 1974; Reisman and Blakeney 1991). For the last 20 years, Benedetti, Peciccia and Donnari have been working specifically with people with a diagnosis of psychosis using various techniques of sensory integration to restore the inner and outer boundaries of the self and to integrate the symbiotic self and the separate self. One of these methods is 'progressive mirror drawing' where therapeutic communication takes place through the integration of three sensory channels: acoustic, visual and tactile (Peciccia and Benedetti 1998). More recently, new technological applications of progressive mirror drawing have introduced new forms of audio-visual sensory motor integration, which we will introduce later in this chapter.

PROGRESSIVE MIRROR DRAWING

Progressive mirror drawing (Peciccia and Benedetti 1989) has similarities with the Squiggle game devised by Winnicott (1953, 1971) as well as some differences. In the Squiggle game Winnicott drew a scribble which a child then turned "into something"; at other times the child drew a shape which the analyst then developed or completed. Progressive mirror drawing is composed of an initial phase in which the patient and therapist simultaneously trace a spontaneous drawing on two different sheets of paper; and a second phase, in which, again simultaneously, the patient completes and transforms the therapist's drawing while the therapist completes and transforms the drawing of the patient.

This technique differs from the Squiggle game in that the patient's responses to the therapist's drawing and the therapist's responses to the patient's drawing do not occur on the same sheet, but on a transparent sheet which can be placed over (union) but remains separate (separation) from the underlying sheet of the other. This difference has some advantages over the Squiggle game for people in psychotic states. In our experience, when a person is in a psychotic state, they can easily experience their self as invaded or overwhelmed if the therapist changes the patient's drawing by acting directly on the sheet with his/her own projections. In progressive mirror drawing, transformations are performed on transparent sheets which are only temporarily superimposed, joined, and then separated from the patient's underlying

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drawing. In this way the drawings, and consequently the patient's internal world and his defensive need to maintain its fragmented state, are respected and kept untouched. This is, in the first phases of the therapy, significant because a therapist's requirement for non-psychotic functioning could be experienced by the patient as an impossible pressure.

In our view, the overlapping of the drawings, made possible by the transparency of the sheets, reflects the movements of union between the drawings of the patient and those of the therapist and of their inner worlds; whilst the separation of the drawings shows the distancing of the two worlds after the symbiotic contact, a sort of re-emergence to the surface after immersion in the inner reality of the other. The repetition of these movements of union and separation between patient and therapist is thought to facilitate the integration between the symbiotic and separate selves. The progressive mirror drawing expresses the therapist's attempt to integrate the symbiotic and separate selves in order to counteract the psychotic split. The alternation between union and separation of an indefinite number of transparent sheets creates a series of images.

In clinical practice, as the case study that follows will demonstrate, the therapist copies the drawings that the patient draws during the session and adds or removes small details. The patient, in turn, copies the therapist's responses, also adding or removing small details. These details are usually significant representations of the affective communication between patient and therapist. Because the drawings are each a slightly modified copy of the previous ones, a graphic sequence is created when they are put next to one another, and there is a clearly recognisable story-line with its own continuity and its own code of visual language, similar to that found in movies and dreams. The therapist's drawings mirror those of the patient and, at the same time, give them a progressive turn. Meanwhile the patient copies graphic elements of the therapist's drawings, and can then shift them, displace them and condense them with other elements that he or she provides by following spontaneous visual associations. In this way the therapist brings what Bion described as 'alpha function' to engage with the patient's fragmented state of mind.

As Peciccia and Benedetti have discussed (2006), one clinical consequence of psychotic fragmentation is that the psychotic person sometimes doesn't speak, or sometimes speaks using words as things. Freud (1915) proposed that in psychosis words undergo the same process which transforms verbal thoughts in dream images. In the clinical case 'Anna', we will illustrate how, by exchanging drawings

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and by using the forms of communication described, it is possible to repair the mental processes fragmented by psychosis and to connect the split fragments of the unconscious of the patient.

In our experience, it is relatively easy for patients to enter this way of communicating and even patients who do not verbalise may go back to using verbal language communicatively while doing so. This happens when, in the dialogue carried out through images, the patient manages to build graphic representations of the 'transitional subjects' composed of parts of the therapist and parts of the patient. These figures entrust the other with emotions which may be expressed with far more intensity than the spoken word allows.

ANNA (THERAPIST: MAURIZIO PECICCIA)

The illustrated story of Anna's therapy will show the clinical application of the theory described so far, and its healing effects in the case of a young woman who was unresponsive to every other treatment.

Anna is a woman who had been diagnosed as psychotic. I met her in 1989 when I was working in the psychiatric clinic in Perugia. She looked very shabby, did not communicate verbally and would persistently repeat a stereotypic act: she continuously covered the area around her eyes with black using everything she had on hand: pencils, pens, paints, shoe polish. When stuck in this stereotypy, Anna demonstrated aggressive and violent behavior. Her sister reported a gradual autistic withdrawal starting in 1979, at the age of 20, after having lived with a peer for a few months. she described how, over a period of 10 years, Anna had excluded herself from all social contacts, shut herself in her room and refused to eat and dine with other family members.

In 1989, when she was almost 30 years old, a colleague, who went on holiday to the Mediterranean island where she lived, heard by accident about a young woman who was kept hidden from social life by her parents, who were ashamed of her 'quirks'. The colleague suggested to one of Anna's sisters, who lived in Perugia, that she should be hospitalised at the department where I worked. There I began to meet her every day for only a few minutes because Anna could not tolerate my presence. Her very brief verbal formulations were incomprehensible and dominated by echolalia and neologism. I too found the dialogue overwhelming because I had the painful impression that she did not understand the meaning of my words and I did not understand her words.

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After fifteen days of hospitalisation, for the first time ever, she replied to my question:

'Do you know where you are?'

'In an eye clinic', she said.

I asked her: 'Why are you in an eye clinic?'

'For eye surgery', she replied.

Although in subsequent meetings she said nothing more that was comprehensible, I began to have confidence that beyond the autistic barrier Anna could understand me and talk. After a few days she answered my question:

'Why are you having eye surgery?'

'They are "pantischi"', she said.

'What do you mean, "pantischi"?' I asked her.

'They are "bad"', was her reply.

I began to internally build a logical connection between the various fragments of Anna's verbalisations:

'My eyes are pantischi, bad. I cover and hide them continuously with all that I have to hand. I'm in an eye clinic to have a surgery and change them.'

I tried to enter her world and asked her to show me on a sheet of paper how she would like her eyes to be after the surgery.

Anna drew a pair of eyes (**Figure 2.1**).

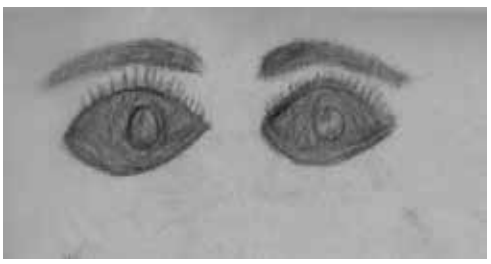

Figure 2.1 • (Patient) First drawing of the patient: her eyes are flooded by green.

I symmetrically copied it (**Figure 2.2**).

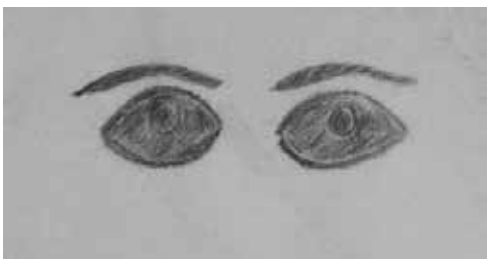

Figure 2.2 • (Therapist): Progressive mirror reply.

I asked her if, after the surgery, she wanted her eyes to be just like that. She then drew eyes again without speaking. For months, countless images of eyes followed, all filled completely by a green colour. From the green, a thin black circle emerged which attempted to show a pupil that was actually absent. The result was an

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expression without a central point of reference, a look lost in the void, lifeless. By looking at the drawing (**Figure 2.1**) I thought about Anna's inability to define her inner world from the outside. The continuous stereotyped repetition, of the act of covering her eyes with black, could be read as a desperate defence against the feelings of invasive penetration that I evoked as I tried to engage with her. I felt that the act of drawing hundreds of eyes on sheets of paper helped her to accept my presence.

After the time period of one month Anna was able to tolerate my presence for a whole hour session. We met 4 days a week, for an hour each day, drawing in silence. The repeated act of covering her eyes with black decreased notably, until one day she spoke the first entirely comprehensible sentence:

'We need to treat the pantischi (bad) eyes with green sea water because they are no longer virgin.'

The meaning seemed quite clear. Anna associated loss of virginity with wickedness of the eyes, which were to be hidden, and asked me to treat them to make them clear and transparent again.

As often happens in the treatment of psychosis, some of the therapist's interpretations, such as this one, need to take place within the therapist's mind alone. They can be communicated to the patient only when they can be experienced as meaningful and helpful. This process can take years.

A few months later, Anna drew a grey quadrilateral picture, which she called 'the UFO (**Figure 2.3**).

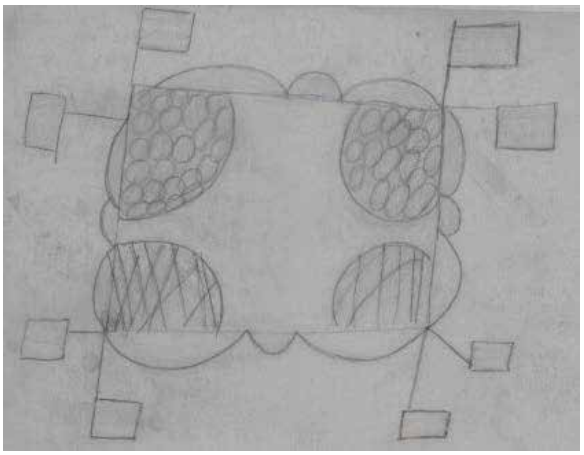

Figure 2.3 • (Patient): The UFO: the starship whose deafening noise terrified Anna.

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Because she could tolerate a few questions, I asked her:

'What is the UFO?'

'The spaceship ... that horrible noise ...', she answered, showing great agitation.

I read on Anna's face an expression of great terror. It seemed that she had at some time come into contact with something awful, unthinkable and inexpressible. In a subsequent meeting Anna added that she had heard the deafening noise of a spaceship in which there were the "bad UFOs" who wanted to destroy the earth (**Figure 2.4**).

At first I interpreted, in the silence of my inner space, the destruction of the earth, caused by the bad UFOs, as the risk of the destruction of herself, caused by the experience of proximity with me. The duality of relationship with the other, presented by the therapeutic relationship seemed to be experienced by Anna as alien and dangerous. In my progressive mirror response I tried to develop graphical elements of her drawing that would open some glimmer of communication.

In examining the antennae belonging to the extraterrestrials, I imagined that the extraterrestrials would be able to exchange thoughts telepathically through their antennae without exposing themselves to verbal dialogue, thus avoiding the risk of psychic invasion that words can evoke when the ego is very fragile. **Figure 2.5** is an example of a progressive mirror drawing in which I copied the two figures (the bad UFOs) of Anna's drawing, adding two small details, the contact between the hands and the contact between the antennae by dots. In the therapeutic drawing my intention was to achieve contact by the duplication, the displacement and the overlap (condensation) of the hands and the antennae of the two figures. Looking at a detail of the image of the contact it seems that the aliens exchange thoughts through their antennae (**Figure 2.6**).

Figure 2.4 • (Patient): the "bad UFOs" who wanted to destroy the earth.

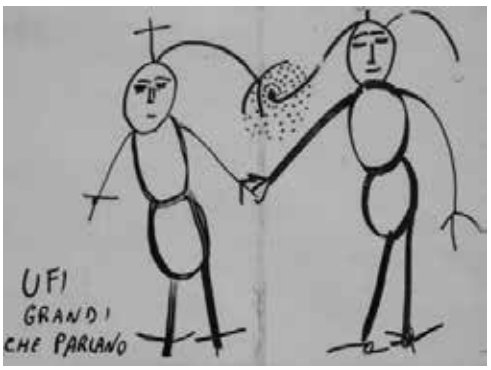

Figure 2.5 • (Therapist): Progressive mirror reply.

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Figure 2.6 • (Therapist): (detail of previous figure) The aliens are exchanging thoughts (dots) through the antennae.

The small dots symbolising thoughts result from repeated duplication of the spherical end of the transmitting antenna. These dots spread like a cloud and wrap the terminals of the two antennae (transmitter and receiver). Altogether, they evoke an idea of the kind of pre-verbal, mental, telepathic communication, in which Anna later revealed that she thought she was immersed.

The possibility of receiving this pre-verbal transmission of thoughts, in the silence of the graphic gesture, can be thought of as an image of containing unthinkable emotions, as described by Bion (1962) in his theory of container-contained relations. It seemed to me that containment was developing in the therapeutic encounter. A few years later, the unbearable affects, which made the relationship with the other so threatening and alienating, emerged. At that stage, Anna was able to tell me that disgusting extraterrestrials came out of the spaceship which forced her to join up with her 'bottom part'. It became apparent to me that the delusion of extra-terrestrials distorted Anna's experience of the sexual violence that she had in reality suffered, to defend her against unbearable anxieties. This was confirmed by the patient's mother, with whom I had an interview, when she came to visit her daughter, on one occasion only. After much hesitation, she told me that her daughter had suffered, for years, repeated sexual abuse by a brother-in-law who was much older than her. In the delusion, the rapist or rapists were inhuman beings, aliens who had destroyed her existence, and not a family member.

At this point I became conscious of the tragedy that lay behind Anna's silence; in her mind, every word, every look could evoke violent penetrations. This was why she shut herself up in silence and imprisoned her expression in black, tried to hide her eyes and

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accordingly, how much she had been forced to see. The intensity of the social taboo of sexual abuse in a family living in a little south Mediterranean island can, in my opinion, be grasped in the psychosomatic reaction of Anna's mother. On the morning after the interview in which she revealed the violence suffered by her daughter to me, she had a sudden stroke that caused her never to speak again.

Anna then drew a pair of plants (**Figure 2.7**).

The plant in the pot on the left has plenty of greenery, flowers and pollen, in contrast with the plant on the right on which there are three bare leaves without flowers that hang from three stems stuck in the arid soil. It seemed to me that Anna, still unable to depict humans, had represented herself in a proto-identity vegetable state, split between the fruitful plant full of vitality, and the arid, barren, dried-up plant. The triangular shape of the three leaves of the plant on the right, crossed by three stems, suggests the repeated violent penetrations which had emptied her life, leaving her deflowered of her fertility and femininity. By introjecting the abuser's destructiveness, the patient continued to attack and destroy her nature, her eyes, her beauty; she felt dirty and defaced, and hid herself behind the heavy and thick black lines, the bars that walled and erased her existence.

I thought that this image also revealed the transference activated by the encounter with the therapist. What will this new relationship bring? Flowers and pollen, or again the penetration which deflowers and empties?

Figure 2.8 is a second example of progressive mirror drawing in which I copied Anna's previous drawing and immersed myself in it, developing and enlivening it with my therapeutic imaging. using 'dream language', as described previously, I duplicated, moved and condensed a stem of the fruitful plant on the left which extends and embraces the leaf of the stripped plant on the right.

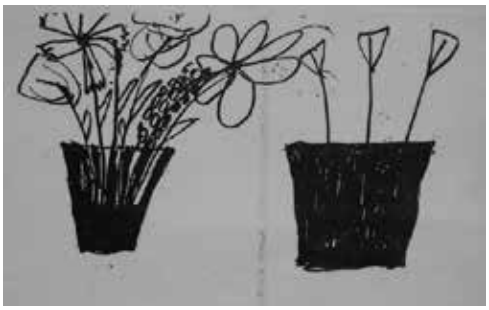

Figure 2.7 • (Patient): The pair of plants.

Figure 2.8 • (Therapist): Therapist's progressive mirror drawing: a stem of the left fruitful plant stretches and embraces the leaf of the right stripped plant.

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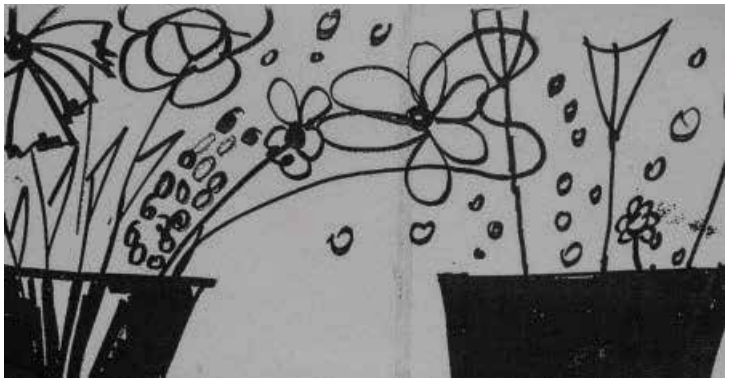

Figure 2.9 • (Therapist): Detail of previous figure.

In **Figure 2.9**, other details of my drawing are highlighted: a cluster transfers its spheres of pollen from the fruitful plant to the sterile plant, thus creating a bridge, a connection between the two plants. One flower of the blooming plant is duplicated, and in my drawing it is moved and transplanted, grafted into the soil of the stripped plant. The duplicated flower becomes part of the stripped plant in a similar way to the condensation dynamic experienced during dreams.

In my description of the images, I intentionally use the impersonal form 'a flower is duplicated, the cluster launches its spheres ... it creates a bridge' to indicate that these images, born in the encounter between our drawings, belong to a transitional area that is relatively independent from the consciousness of patient and therapist. This establishes a distance from consciousness that can help to overcome the resistances of both patient and therapist to getting in touch prematurely with unthinkable emotions whose intensity is capable of disorganising thinking. Only after thirteen years of regular production of images was it possible to talk with Anna about her trauma.

In **Figure 2.10** Anna's imagery changes from the vegetable world to the animal world; and seems to me to depict the relationship in its maternal, protective, therapeutic variant. I responded with a progressive mirror drawing where the adult cat approaches the child cat.

Anna reacted to my image by saying a sentence full of meaning:

'Write on the paper: the good mother, the child waiting for milk' (**Figure 2.11**)
These words surprised me because they were cognitively and affectively much more evolved than the usual disconnected communications of those times.

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Figure 2.10 • (Patient): The good grey cats.

Figure 2.11 • (Therapist): Write on the paper: the good mother, the child waiting for the milk.

Then Anna drew the transition from the animal world to the human world (**Figure 2.12**).

This seemed to me to present the therapeutic relationship as a pair of rabbits with a human face in which a kneeling rabbit seems to ask for support from the other. In my progressive mirror reply I move and place the two rabbits closer (**Figure 2.13**).

Figure 2.12 • (Patient): A pair of rabbits with human faces in which the one kneeling seems to ask for support from the other.

Figure 2.13 • (Therapist): Progressive mirror reply.

The joined arms create solidarity and a supporting bridge between the two rabbits. The connection between the arms of the two figures reminded me of the pollen bridge (**Figure 2.9**) that linked the lush plant and the bare plant.

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The first human figure drawn by Anna was a child that she called 'Pollino' (**Figure 2.14**).

The unconscious choice of the name seems linked to the pollen through which the two plants had entered into a relationship. The pollen was a bridge. It seemed to me that this was a transition between her and me, as well as between her lush, fertile potentialities and her arid and sterile nuclei. The coloured crayons in the image were the means which had structured the intra-psychic and interpersonal communication. This figure is a graphic representation of what I described earlier as a transitional subject (Benedetti and Peciccia 1989; Benedetti 1991, 1992), born in the intersubjective field co-created by patient and therapist, and made up of parts of the patient (her eyes covered by black) and parts of the therapist (the coloured crayons introduced by me to communicate).

In the next drawing Anna for the first time portrayed her face (**Figure 2.15**).

The 'sick eyes that needed surgery because they had lost their virginity' are now opened, filled with sea-green liquids. Sea green was the colour that she had used in her early images, that was supposed to treat the 'bad, pantischi' eyes. During that time I dreamed of Anna with two apples corresponding to the breasts, two pears as the hips and two peaches as the ovaries. I connected the dream image to the development of her femininity in the therapeutic relationship: apples, pears, and peaches as symbols of the plant world were placed along the milk lines which in mammals run through the zones of fertility, reproduction and lactation.

Figure 2.14 • (Patient): Pollino, a transitional subject made up of parts of the patient and the therapist.

Figure 2.15 • (Patient): The first of Anna's self-representations.

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Figure 2.16 • (Patient): The fiancée!.

Figure 2.17 • (Therapist): The gift of the flower.

Anna then drew what seemed to me to be a presentation of the therapeutic relationship using two human figures: the engaged couple (**Figure 2.16**).

Maintaining the connection with the plant world, she names the girlfriend Melina (little Apple) and the boyfriend pino (pine). This connection can also be perceived in the flowerpot placed on the table on the right of the boyfriend.

In my response, the boyfriend gives a flower to his girlfriend (**Figure 2.17**).

Even in this case, the movement of the flower from the pot to the hands came from duplicating and moving a flower and uniting it with the hands.

In my thinking, the gift of the flower is 're-flowering', a symbol of a delicate relationship which, in the therapeutic distance, is very different from violent de-flowering. The two lovers in my drawing are crying: the sharing of tears has become the salt water which cleanses Anna's eyes. In her response Anna, who still spoke in fragments, asked me to write the boyfriend's text while she wrote his girlfriend's words in coherent form (**Figure 2.18**).

Figure 2.18 • (Therapist and Patient): T: I brought you these flowers as a gift, Melina P: Thank you for the flowers, Pine.

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Figure 2.19 • Detail of the previous drawing: the 'in-florazione'.

Looking at a detail of the image (**Figure 2.19**) we can see that the black petal is in transition between the flower and the eye of the girlfriend, and could be seen as going either way.

The black with which Anna erased her eyes seems to have been absorbed by the flower. In the next drawing (**Figure 2.20**) Anna wrote this text for the girlfriend: 'My boyfriend says that my eyes are open and clean'.

Figure 2.20 • (Patient): My eyes are open and clean.

The reader may wonder why Anna wrote: 'My boyfriend says that my eyes are open and clean', when in fact he has only stated in the text (**Figure 2.18**): 'I brought you these flowers as a gift'.

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In order to give a possible answer, it is necessary to remember that the young woman felt that her eyes were dirty, no longer virgin, and therefore needed to be hidden and changed. It is likely that there was a 'symbolic equivalence' between the vagina and the eyes similar to that described by Hanna Segal (1950), whose musician patient did not want to play cello in public because he feared that everyone could recognise, in this very act, his masturbation. Similarly, by equating the eyes with the genitals, Anna's violated body zone was defensively shifted 'from the bottom toward the top'. Maybe Anna feared that the violent loss of virginity, shifted and condensed in the eyes, could be seen by everyone, so she forced herself to hide the shame and guilt associated with the violence, hiding herself and her eyes in total social withdrawal.

Communication through images, which is based primarily on processes of duplication, displacement and condensation, as described in the introductory section, offered a loving relationship in which Anna received love without being deflowered, indeed by receiving flowers. My interpretation is that this gift, which I previously defined as 're-flowering', is understood by Anna's unconscious as restitution of virginity. This resolves the symbolic equivalence and frees her eyes to see reality. Maybe this is why she writes: "My boyfriend says: my eyes are open and clean". In many languages, the loss of virginity is defined as deflowering whereas the gift of the flower is associated with intimacy, desire, respect, and at the same time with virginity. I am thinking specifically of the many images, painted within the Christian religious tradition, of the Annunciation in which the Angel Gabriel brings flowers, often white lilies, to the Madonna, such as the 'Annunciation' painted by Andrea Della Robbia.

Freud (1900) has repeatedly noted that flowers are the sexual organs of plants. In the vegetable world there is no penetration but a sexual relationship at a distance; the plants are fertilised without touching, entrusting their seeds to the wind. The wind with its lightness and its spiritual consistency is the bearer of life among plants. The gift of the flower, the "re-flowering", evokes the restitution of virginity and could be also a symbol of the therapeutic relationship, restoring the intimacy of psychic closeness. In this dimension of spiritual union, the images in the drawings, as well as the flowers, fertilise each other at a distance, even in the absence of contact between the bodies. This virginal intimacy can be seen as making it possible for the patient to get in touch with the split emotions of her violated sexuality; first through the images, and later also through words, which reconstructed and elaborated the traumatic experiences of the abuse.

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Here are her drawings in succession: the kiss of the engaged couple (**Figure 2.21**), their wedding (**Figure 2.22**), their first night (**Figure 2.23**), her pregnancy (**Figure 2.24**).

Figure 2.21 • (Patient): The kiss.

Figure 2.22 • (Patient): The wedding.

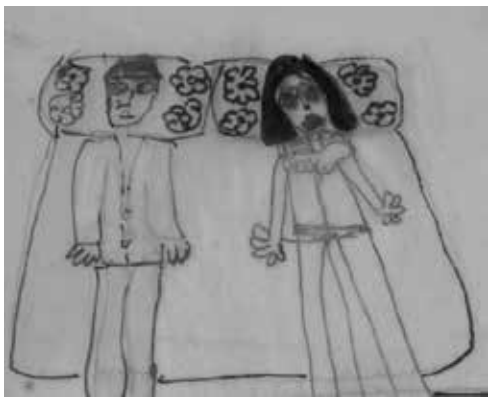

Figure 2.23 • (Patient): The first night.

Figure 2.24 • (Patient): Pregnancy.

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Later Anna drew the birth of the child, a son who needs a name (**Figure 2.25**). It seemed to me that Anna, through the son, was renewing her identity.

Figure 2.25 • (Patient): Salvatore.

Indeed, she wrote these words on the mother's text: 'my baby, I have to prepare for him a name: Salvatore (Saviour).' At this point the problem of good or bad milk emerged. Anna wrote the following on **Figure 2.26**:

Figure 2.26 • (Patient): Salvatore, is the milk sweet or bitter?

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This seemed to me to be saying: 'as a child, did I receive good or toxic milk? Was my mother's womb good or bad? As a result are my breasts and my milk good or bad?', and at the same time, in the transference: 'Is the therapist's milk good or bad? Is he nourishing me or poisoning me?' Salvatore is a transitional subject, the son of the therapeutic relationship, co-constructed by patient and therapist. This child believes in the goodness and beauty of the milk of his mother who instead does not seem sure if her milk is good or bad, i.e. if she is good or bad. Indeed, Anna put the following words into Salvatore's mouth (**Figure 2.27**):

Figure 2.27 • (Patient): Mum give me the milk that comes out of your breast: I'm sure it's very beautiful.

These words seemed to me to say that her child-self, entrusted to the care of the therapeutic relationship, can feed on milk that will not be bitter, toxic, destructive, but instead good.

Gradually, the exchange of drawings between patient and therapist created a series of evolutionary stages of relationship that moved from the mechanical world of the aliens (**Figures 2.3, 2.4, and 2.5**), to the vegetable world (**Figures 2.7 and 2.8**), and the animal world (**Figures 2.10 to 2.13**), before reaching the human world (**Figure 2.14 et seq.**). The human representations of the self and the other, loving each other and becoming fertile, could be seen as creating a new self, a transitional subject giving a new healthy identity to Anna.

While she drew, Anna spoke with great difficulty. Her written sentences for the characters of the drawings were much clearer than her spoken sentences. Her relationship with reality was severely altered, she did not have a sense of time, space or other realities such as money. Her relationship with me was dominated by autism

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(i.e. an extreme need to be separated from me, not integrated with the desire to be united with me). I often had the feeling of the uselessness of my presence, and sometimes I felt inclined to act as if she was not there.

The recovery of verbal language and of the relationship with reality proceeded in parallel with the development of what has been described as a 'progressive psychopathology' (Benedetti 1980)9, characterised by delusions that, while deforming reality, gradually opened up communication and reduced the autistic barriers. The first delusional 'progressive' communication was that of the bad 'pantischi' eyes, which needed to be operated on to make them as green as the sea. The neologism 'pantischi' stemmed from combining the name of the island where she was born and the adjective 'disgusting'. I saw Anna's identity as formed in my green eyes watching her, just as the identity of the child is formed in the eyes of the mother. The request to operate on the pantischi bad eyes, to make them become good, green and virginal, is a progressive delusion in the sense that it contains elements which defensively deform reality but at the same time it is the first verbal communication toward the therapist. Anna asked to be looked at, to be loved and not to be preyed upon. By looking at her with respect, I felt I was able to reflect the dignity of her existence, so that she felt that her eyes could be clean and virginal again. 'My boyfriend says my eyes are open and clean', Anna wrote to her little Apple who had received a gift of flowers from my Pine. It seems to me that the therapeutic communication enabled Anna to open up her view of reality. Her eyes no longer needed to be erased by black, by shame or by guilt; they could be born again in beauty.

Anna then developed a second progressive delusion based on her memory of meetings with the beautiful eyes of the virgin Mary, who would cry, fearing her death, when she looked at her. At other times the Madonna encouraged her to undergo eye surgery. Maybe Anna, due to the introjection of the violence suffered, projected on to the virgin Mary's beautiful, idealised eyes her good self that had been split from her bad self (the dirty black eyes that were no longer virgin). Through the therapy, there is a meeting between 'good' and 'bad' selves which could lead to a necessary but also dangerous transformation. The good self (the beautiful eyes) is in danger of being destroyed by the destructiveness of the bad self. In the psychodynamics of the violence, the dirty and bad eyes seem to represent the introjection of the abuser's evil look and Anna is compelled to delete them with the colour black. The danger of being destroyed by the evil can be seen as activating two primitive defence mechanisms: the splitting of the good self from the bad self and the projection of the good outside, into the idealised eyes of the Madonna. The otherworldly vision of the Madonna is then embodied in the reality of the therapeutic relationship.

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The tangible exchange of looks with me seemed to put her back in contact with her sense of herself: Anna, through her drawing of the 'little Apple', generated a son with the therapist, and called him 'Salvatore', Saviour, the name of the virgin Mary's son. Salvatore, Saviour, is what I have defined earlier as a transitional subject, an analytic third, co-constructed by patient and analyst. As the son of the couple he believes in the goodness and beauty of his mother's milk. The mother does not seem sure if her milk is good or bad, that is, if she is good or bad. But Salvatore is not only the symbol of the child self, entrusted to the care of the relationship, to feeding, to a milk that detoxifies, he is also the son of a loving relationship experienced in the protective distance of the creative space, very different from the traumatic relationship that Anna experienced in the sexual violence. Salvatore is an inter-subjective figure, simultaneously solidly drawn and fantastically imagined, and in my view, was the basis of a new identity, representing the nourishment that strengthens the self and makes intolerable and undigested emotions thinkable.

After thirteen years of therapy, Anna was able to reconstruct and talk about the years of shame, marked by the repeated abuse by her brother-in-law. She remembered having had an abortion, in which she felt the child of the violence had been ripped from her womb in her state of total helplessness. Salvatore was very different from her unnamed unborn child with no identity, and her sense of herself in relation to Salvatore was very different from her previous sense of non-existence, as a woman and a mother.

After Anna had fully reconstructed and communicated the traumas, of the sexual violence and the consequent abortion, her delusions ceased. Benedetti (1980) has described this process, that happens through the development of a series of progressive delusions which tell of a reality that is unbearable and must therefore be deformed. The first time Anna spoke of sexual violence was through the delusional memory of an old man who had raped her and sent a werewolf towards her, wanting to devour her. This idea suggests that the abuse had unleashed conflicts of both genital and pre-genital natures which devoured the patient's self, turning the image of her rapist into a werewolf in her mind. One aspect of the dynamics of abuse is that the abused victim introjects the monstrosity of the abuser (A. Freud 1936), as can be seen in a drawing (**Figure 2.28**) by Anna at that time in which she takes on the appearance of a monster.

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Figure 2.28 • (Patient): Deformation of the face caused by the introjection of the monstrous face of the abuser.

In this sense, the violence devours the identity of the victim who is forced to identify herself with and to internalise the destructiveness of, her aggressor who disorganises her thoughts and her relationship with reality. The recovery of verbal language and the development of confidence in me, which in the transference lessened the fear of being abused again, allowed her to tell me her sexual fantasies as she began to elaborate her conflicting experiences related to the trauma. She revealed to me that, within her, eyes and sex were 'connected'. Therefore, certain eye movements corresponded to sexual movements. Anna said to me: "I've done it so many times with you: didn't you ever realise?". With this question she revealed her desire and at the same time she began to doubt the idea that every look corresponds to a sexual penetration, a certainty she had lived with for years. This is how differentiation between the self and the other emerged, as a natural border which protected her without the need for an autistic barrier which radically separated herself from the world and from others. In the relationship with me, Anna was able to work through a painful conflict. On the one hand, there was her desire to be with me; "to be whole: in terms of feelings, the soul and sex". On the other hand, there was the fear that I too, like the rapist, the old man with the werewolf and the alien, could force her into a sexual union that would destroy her identity.

Anna alternated between moments in which she looked at me intensely and "did it" with me, feeling like: "a child embedded in and embraced by her mother". At other times, out of fear, she defended herself autistically from me. Then, an atmosphere of mutual emotional denial of the presence of the other was created. Both patient and

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therapist entered into this denial in response to the deep feelings generated by the presence of the other. Consequently, we both behaved as if we were alone and not together during the therapeutic session. The creation of a graphic-affective dimension of the therapeutic encounter allowed us to 'operate' on a double level of differentiation and of union. This mitigated the intensity of the conflict between opposite emotions: those that related to the frustrated longing for symbiotic fusion, and those that related to the need for radical, autistic separation. Also through words, once recovered, we were able to work on the dual plan of union and separation by integrating these deeply split dimensions. On the symbiotic side, there was the possibility of developing fantasies of sentimental and sexual union; on the level of separation, it was possible for Anna to accept the fact that, to her great surprise, no one could read her eyes. She became able to tolerate the frustration of the symbiotic needs she experienced, and she felt protected because I was not aware of the sexual intercourse between our eyes. The internalisation of a deep dimension of emotional union with the therapist enabled her to accept separateness and eliminated the need to protect herself by using delusional and autistic defences.

DEVELOPMENTS IN PROGRESSIVE MIRROR DRAWING AND OTHER SENSORY INTEGRATION TECHNIQUES (SIMONE DONNARI)

In the years since Anna's therapy several new technologies have added to the range of media available for image-making in therapy, and I will now discuss some of the developments in progressive mirror drawing that these have made possible in individual therapy and in groups. In my own practice I have sought to incorporate some of these within a particular group framework, where the group consists of several patient-therapist couples sitting together in a circle. During the image-making session, all the couples will make images at the same time, but exchanges of images happen only on a one-to-one basis within each patient-therapist couple. The main innovation offered by new technologies seems to me to be the opportunity to draw and interact with images simply by using one's own body, without the requirement of learning the skills needed to use keyboard, joystick, or other tools. Simply by moving, the patient can easily play music, draw and by doing so, integrate many sensory pathways. In the last 15 years, many sensory integration media have become available due to the emergence of new technologies and game consoles, and my attention has been focused on using these to develop techniques to create sensory and motor synesthetic experiences that could enhance the therapeutic intervention of progressive mirror drawing. I found that popular game consoles offered a precious and unexpected therapeutic medium, but it was the effects of the application of digital videocameras

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(video-art therapy) that started an innovative process. I will now discuss four specific applications of new technologies: video-art therapy, progressive mirror drawing animation, motion detection devices and sensory motor integration, and a technique that I have named 'the puzzle of the self''.

VIDEO-ART THERAPY

Since 2001, I have introduced a video camera into the progressive mirror drawing group therapy setting. The operator is one of the therapists. Digital cameras allow the operator to edit and cut the video in real-time. They come with embedded software that offers the possibility of performing cross-fading and mixing of frames during shooting. Thus it became possible to make a video during the therapy session and show it to the patients immediately after. Real-time editing avoids the delays involved in post-production editing and makes it possible to watch the video immediately after the therapy session.

When the group image-making activity ends, the 'distancing phase' described by Rubin (1987) takes place. During this step the maker creates a distance between himself and the image he created. "The powerful emotions contained in the visual product can now be viewed with a certain measure of detachment" (Rubin 1987). During this phase, showing the video of the session reinforces the distancing process and offers the patient's self an opportunity to play the 'observer role'. While distancing from his or her own work, the participant also shares his production with the group, giving it back to the group in which the drawing process happened. This phase can be called 'restitution', and I have described elsewhere (Donnari 2011) the great potential of video as a restitution tool, because by watching the video every participant can see the images of the others, and they can be experienced as the property of the group.

In my experience, the customary use of video cameras as recorders in therapy settings can often be disliked by patients, but when they are used in the way that I describe, I have found that patients often express appreciation for the opportunity to see themselves in the video. In this way of working, the opportunity to watch the video immediately after the therapy session offers the patient the possibility of flowing from the actor-player role (symbiotic self) to the watcher-observer one (separate self). For instance, cross-fading a drawing detail with the picture of the face of its author in the video can strongly convey a message of identity in the distancing phase. Over time, we have found that patients become accustomed to the video camera and perceive it as an art tool, like brushes or colours. The video camera can record images from previous therapy sessions, thus allowing cross-fading effects from bodies to drawings and

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images, enabling the video to become an actual visual integration between body movements and images, between the act of drawing and the resulting image.

Cross-fading and other editing effects between old and new drawings can create a variation on the theme of merging between old and new which is another of the typical dream dynamics, described by Freud (1900), that we referred to earlier. It seems to me that the medium of video enables experiences of union and separation between the patient's body and the symbols in his drawings to be easily accepted. Through video editing one image can slowly be transformed into another one via "morphing", a visual transformation that creates an animation starting from static drawings. This effect is powerful and eye-catching because it introduces a visual equivalent to dreamlike motion. Morphing of separate images means watching the first one gradually become the second one, which is like a visual translation of the mechanisms of condensation and separation that are experienced in dreams. It seems to me that these dynamics help with the work of healing the break-up between the separate and symbiotic selves by 'training' the patient to oscillate between symbiosis and separation.

In individual therapy, images made by the therapist and the patient are animated through the video and become a sort of 'communal dream' of the therapeutic couple in a similar way to the process described in the clinical example of progressive mirror drawing. The video non-verbally shows emotions not always understood or perceived during the action, and underlines the symbolic meaning of the experience with a moving dream-like language.

PROGRESSIVE MIRROR DRAWING ANIMATION

As discussed elsewhere, we have found that tablets and touch-screen devices are also useful media in the field of progressive mirror drawing therapy (Donnari, Peciccia *et al.* 2013). Drawings can be made directly on the tablet or uploaded to it, and then the many digital tools offered by the tablet can contribute to the patient-therapist interaction with the images. Symbols can be isolated from the image and then animated and translated. The patient can operate shifting, condensation and many other dreamlike mechanisms just with his fingers. For example, with his finger on the touch screen the patient can draw the image of a butterfly. Then he can move the butterfly in a different part of the screen (shifting), or he can merge the butterfly with another drawing, e.g. a flower (condensation), and can easily transform the drawing and its symbols. No technical knowledge is required to apply this technique, which is extremely easy and intuitive. Images can be simultaneously projected onto a large screen while being drawn.

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In individual therapy, the patient draws freely with his fingers on the touch screen device. By connecting this device to a large screen in the therapy setting, the drawing of the patient is immediately visible and enlarged. The image on the screen becomes the frame of the therapy setting. The patient and therapist are surrounded by the image, and while the image is being drawn they are immersed in visual feedback of the experience. Drawing animation is immediately available on touch-screen tablets. Patient and therapist can actively interact with pieces of the drawing, creating experiences of shifting and condensation by morphing, which, as discussed earlier, seems to us to tap into dreaming mechanisms. We think this is a powerful way to move from symbiosis to separation without raising anxieties for the patient. In these ways, video and digital imaging tools have enhanced the previously described integration effect of progressive mirror drawing.

MOTION DETECTION DEVICES AND SENSORY MOTOR INTEGRATION

More recently, the advent of contemporary video-game consoles has given further opportunities for sensory integration. Game consoles allowed body movements to be translated into drawings which are projected onto a large screen in front of the therapist and patient (**Figure 2.29**).

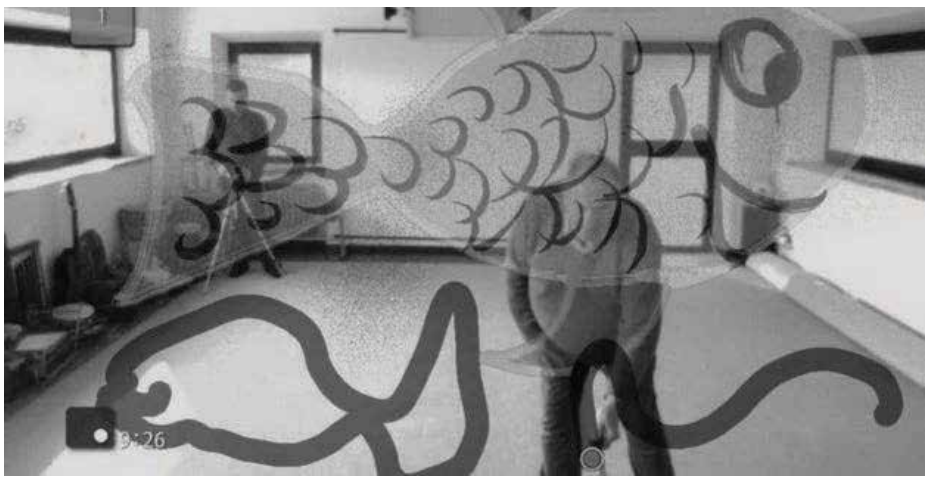

Figure 2.29

Body images projected on the screen then become condensed with the drawings initiated by body movements. the relationship between patient and therapist is indirectly realised on the screen. The screen becomes an interpersonal space where the patient can learn to tolerate facing the image of his own body, an experience which

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is often avoided as it can be a source of anxiety. Both therapist and patient can see themselves on the screen while producing luminous beams and sounds by moving their own bodies. The session can start from an image that carries affective meaning for the patient. For example, the patient can draw a leafless tree which testifies to his feeling of loneliness. The image is reproduced on the screen by the movements of patient's and therapist's bodies. Movement and image are integrated on the screen, and body movements work as a drawing tool. Moreover, the system allows both the drawn image and the reflection of the bodies of the patient and therapist while drawing it to be seen.

On the screen, it is possible to see a merging of one's own body and one's own meaningful images and symbols. The patient can experience himself as the actor because he is the one who makes the drawing, and at the same time as an observer because he can see himself in the 'mirror' of the screen. We have found that this technique seems especially helpful for patients with stereotypical movements, such as patients with autistic features. By watching their own images on the screen and experimenting with the visual effects of their body movements, watching themselves while rocking or incessantly rotating one hand, the patients can often find a purpose in every movement and this can enable them to overcome stereotypical gestures and use the body movement for a definite purpose, for example, to generate a beam of light that is visible on the screen (**Fig. 2.30**). Furthermore, patients who feel threatened by new environments seem to react positively when they can watch themselves next to the therapist in the mirror of a screen that seems to contain the entire room.

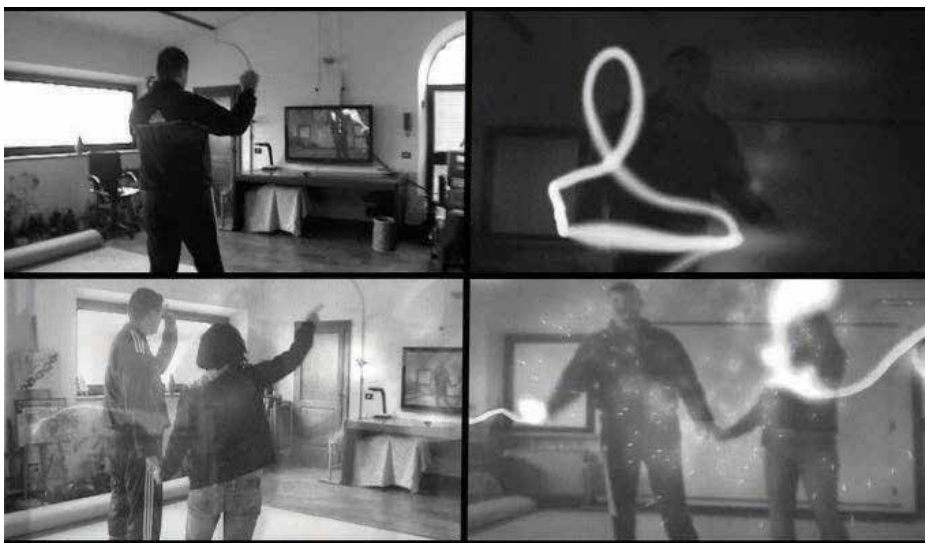

Figure 2.30

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THE PUZZLE OF THE SELF

I have also developed a specific technique that I have called 'the puzzle of the self', in which hundreds of images and video frames created in different therapeutic settings are processed by software and then used to create a single 'puzzle' image of the face of the patient. The elaborated image represents the face of the patient made by small pieces. Each piece is a drawing or a video frame made during mirror drawing therapy sessions.

All the different therapeutic techniques described in this chapter aim to create protected spaces, initially external to the patient, where the self's split fragments may be placed in order that they may become available to being 'dreamed' through the techniques that we have described, and to the other forms of healing available within the therapeutic relationship. We can imagine these split fragments as pieces of a blurred puzzle waiting to be put into order and become for the patient a mirror of an integrated and coherent identity. Our digital techniques are able to help the patient to 'solve the puzzle' by starting to 'dream outside himself', integrating both symbiosis and separation experiences. This aims to give the patient an integrated image of the self which can be internalised as a secure and constant symbol.

SENSORY MOTOR INTEGRATION AND FUTURE DEVELOPMENTS

As discussed, we think that technology seems capable of amplifying the symbolisation dynamics of drawings and dreaming. Moreover, it can be appealing for patients. Most present day patients are 'digital natives' (Prensky 2001) so they are well accustomed to new technological media, and we have found that it can be valuable to use the same tools that patients often use on their own in the therapeutic frame. The current trend in video games towards enhancing virtual sensations is proceeding in the direction of greater sensory integration, and the authors are confident that this will offer further opportunities for developing therapeutic applications (Donnari and Peciccia 2013). Furthermore, a team of researchers and engineers have developed a customer-designed software capable of fine-tuning the rehabilitation tools according to the rehabilitation needs of patients diagnosed with psychotic or autistic spectrum disorders (paINTeraction technique, **Figure 2.31**). Body movements can generate drawings, light trails and avatar animation. The software can also record kinetic and autonomic parameters for research studies. By accessing the software, a community of parents and therapists is built around every patient, developing a closer connection between therapy and 'real life' issues.

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Figure 2.31

CONCLUSIONS

In this chapter we have introduced the therapeutic technique of 'progressive mirror drawing'. Referring to the work of psychoanalysts working with psychotic patients, we introduced ideas about the impact of psychotic fragmentation on dreaming, in the usual sense of the word, and on the use of verbal language. The theoretical basis of progressive mirror drawing is Benedetti and Peciccia's interpretation of psychosis as a result of a split between 'symbiotic self' and 'separate self', one of the consequences of which is that the capacity to dream is hindered. While dreaming, we repeatedly fluctuate between the position of observers, separated-by, and the position of participants, immersed-in the dream (Benedetti and Peciccia 1995). In psychotic patients these fluctuations can generate fears of fragmentation and annihilation that hinder the possibility of dreaming 'internally' and compel the patients to project out split fragments of their self. Racamier (1976) called this process 'dreaming out'. Our clinical approach is aimed at therapist and patient 'dreaming out together'.

We discussed the challenges that working with people in psychotic states present to the therapist, because of the extreme anxieties being suffered by the patient, and suggest that these are minimised by the technique of progressive mirror drawing. The technique, and its evolution over the past 20 years, was described and illustrated by a clinical case study. Our description of the technique of progressive mirror

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drawing started with a discussion of its similarities with, and differences from Winnicott's 'Squiggle game'. Both are based on the exchange of images between the therapist and the patient, but progressive mirror drawing has significant differences that take account of the patient's vulnerability to feeling invaded by the therapist's image-making.

In progressive mirror drawing images are 'dreamed together' because patient and therapist move, displace and condense them using processes that are equivalent to the dream mechanisms described by Freud (1900). We have introduced the concepts of 'progressive delusions' (Benedetti 1980) and 'transitional subjects' (Peciccia and Benedetti 1989) to describe the images and other experiences that evolve in the intersubjective field established by our approach, and the concepts are linked to a clinical study that shows in detail the way that one patient made use of the approach to emerge from psychotic fragmentation. We propose that, over time, the multisensory and sensory motor integration techniques of art therapy described in this paper can bring about a shift out of psychotic fragmentation, restore the capacity for thinking, rebuild the representations of self and other and facilitate the development of a differentiated sense of self in psychotic patients. We have discussed these aims with reference to contemporary neurophysiological research, which shows that multisensory integration neural circuits are responsible for self-other distinction and that these circuits are connected with the self-other identification circuits (Mirror Neuron system). Demonstrations of neurophysiological alterations in areas related to the functions of both self-other identification and of self-other differentiation in psychotic states, offer the neural basis for those psychodynamic theories that suggest a lack of integration between symbiosis and separation in psychosis. Furthermore, they open the possibility for empirical research on the efficacy of art therapies and other psychosocial therapies for the recovery of the sense of the self in psychoses.