ABSTRACT

COMPARING THE EXPERIENTIAL CONSTRUCTIVIST DIAGNOSTIC SYSTEM AND THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: TESTING AN ALTERNATIVE TO THE MEDICALIZATION OF HUMAN DISTRESS

by Anthony John Pavlo

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM; APA, 2000) has a monopoly on conceptualizing human pain and distress. While many authors have criticized the DSM on a number of fronts, the DSM continues to dominate and few viable alternatives that overcome these critiques have been promoted. This paper reports on one such alternative, the Experiential Constructivist Diagnostic System (Leitner, Faidley & Celentana, 2000), and a qualitative research study that compared participants’ perceptions of their DSM and experiential constructivist diagnoses. I provided four participants who had experienced severe relational injuries with both their experiential constructivist and DSM diagnoses. After receiving the diagnoses, participants then discussed their understandings of the diagnoses. Participants not only found the experiential constructivist diagnosis more accurate but also found the experiential constructivist diagnosis more respectful and useful, as it allowed them to access deeper emotional struggles.
COMPARING THE EXPERIENTIAL CONSTRUCTIVIST DIAGNOSTIC SYSTEM AND
THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: TESTING
AN ALTERNATIVE TO THE MEDICALIZATION OF HUMAN DISTRESS

A Thesis

Submitted to the
Faculty of Miami University
in partial fulfillment of
the requirements for the degree of
Master of Arts
Department of Psychology
by
Anthony John Pavlo
Miami University
Oxford, Ohio
2008

Advisor_____________________________________
Larry M. Leitner, Ph.D.

Reader_____________________________________
Roger M. Knudson, Ph.D.

Reader_____________________________________
Christopher R. Wellin, Ph.D.
Table of Contents

Introduction ......................................................................................................................... 1
  Researcher Positioning .................................................................................................. 1
  Criticisms of DSM ........................................................................................................ 2
  Experiential Constructivism ........................................................................................... 3
  Experiential Constructivism and the DSM ................................................................. 5
  The Experiential Constructivist Diagnostic System ...................................................... 6
    Developmental Issues/Structural Arrests ................................................................. 7
  Interpersonal Components ............................................................................................ 8
  Experiential Components .............................................................................................. 9

Method ............................................................................................................................. 13
  Participants .................................................................................................................... 13
  Procedure and Materials ............................................................................................... 13
    Diagnosing ................................................................................................................ 13
    Presentation to Participants ....................................................................................... 15
    Analysis ..................................................................................................................... 16

Results ............................................................................................................................. 17
  Simon ............................................................................................................................ 18
    Diagnostic Interview ................................................................................................. 18
    Preparation of the Experiential Constructivist Diagnosis ..................................... 26
    Validation of the DSM Diagnosis ............................................................................. 35
    Presentation of Experiential Constructivist Diagnosis ........................................... 39
    Presentation of DSM Diagnosis .............................................................................. 54
    Fourth and Fifth Interviews ...................................................................................... 68
  Janet ............................................................................................................................... 69
    Diagnostic Interview ................................................................................................. 69
    Preparation of the Experiential Constructivist Diagnosis ..................................... 85
    Validation of the DSM Diagnosis ............................................................................. 93
    Presentation of DSM Diagnosis .............................................................................. 96
    Presentation of Experiential Constructivist Diagnosis ........................................... 107
  David ............................................................................................................................ 113
    Diagnostic Interview ................................................................................................. 114
    Preparation of the Experiential Constructivist Diagnosis ..................................... 133
    Validation of the DSM Diagnosis ............................................................................. 141
    Presentation of Experiential Constructivist Diagnosis ........................................... 144
    Presentation of DSM Diagnosis .............................................................................. 158
  Alan .............................................................................................................................. 169
    Diagnostic Interview ................................................................................................. 169
    Preparation of the Experiential Constructivist Diagnosis ..................................... 187
    Validation of the DSM Diagnosis ............................................................................. 196
    Presentation of DSM Diagnosis .............................................................................. 198
    Presentation of Experiential Constructivist Diagnosis ........................................... 205
Acknowledgments

I would like to thank my advisor, Larry Leitner, who inspired me to undertake the project. His support, patience and guidance have been invaluable in my growth, both professionally and personally, and the project could not have been successful without his support. I would also like to thank my committee members, Roger Knudson and Christopher Wellin, for their thoughtful feedback and suggestions. I would also like to thank Alexandra Adame, Kathy Conaway, Jonathan Fishman, Rachel Hamilton, Corinne Hoener, Siri Hoogen, Valerie Loeffler, Julie Lonoff, Jim Mosher, Hugo Schielke, Brendon Smith and Rachel Stern for their help constructing diagnoses, providing thoughtful commentary on the data, and supporting my work. The project would have been infinitely more difficult without Rachel Stern’s help with transcriptions and thoughts on the data. This work could not have been completed without the support and love of Annette Orzechowski. Finally, I would like to thank my participants for having the courage to share their stories with me.
Comparing the Experiential Constructivist Diagnostic System and the Diagnostic and Statistical Manual of Mental Disorders: Testing an alternative to the medicalization of human distress

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM; APA, 2000) has, from its inception, been the target of criticism (e.g., Caplan, 1995; Cushman, 2002; Honos-Webb & Leitner, 2001; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997; Leitner, 2005; Leitner & Phillips, 2003; Sarbin, 1997; among others). These critiques range from questioning the empirical basis of the DSM (Kirk & Kutchins, 1992) to highlighting the effects of DSM diagnoses and rationality on the patient’s psyche (Cushman, 2002; Honos-Webb & Leitner, 2001). While these critical evaluations of the DSM have lead to some alternative diagnostic systems (see Beach & Kaslow, 2006; Beutler & Malik, 2002; Follette, 1996; Neimeyer & Raskin, 2000), there has been little research on these alternatives to the DSM. In this study, I will compare the DSM and one such alternative system—the experiential constructivist diagnostic system proposed by Leitner, Faidley, & Celentana (2000). Specifically, I will compare the DSM and experiential constructivist diagnostic systems in terms of their relevance for clients' understandings of their struggles. Before describing the study in more detail, I will briefly articulate my position in the present research and my stance on the DSM. Next, I will describe experiential constructivism as well as the experiential constructivist diagnostic system. I then will describe the study more fully.

Researcher Positioning

I would like to discuss my position in the present research, as I come to the project with certain biases against the DSM. When I began graduate studies, I was interested in existential and phenomenological approaches to psychology, approaches that are not easily compatible with medical model understandings of human struggles. As I articulated my position over the course of the project, I grew concerned that the DSM and the disease model of psychopathology hindered person’s ability to live meaningfully. During my psychotherapy training, I experienced how persons diagnosed with DSM labels utilized medical constructions of psychopathology in their lives. Essentially, I came to believe that DSM labels have the power to silence persons, as human experiences, such as sadness, worry and hearing voices, became symptoms to remove or reduce. During my training, especially when I worked with clients with severe labels, I often struggled because I wanted to give voice to the misunderstood.
The reader should be aware of my perspective, as my thoughts, arguments and interpretations cannot be fully understood without knowledge of my own biases. For instance, I tried to have a balanced perspective while interviewing clients. But, at times, I worried that I let participants speak about the experiential constructivist diagnosis at length. I also felt that I forced clients to discuss the DSM in depth, as I did not want to be biased against the DSM. My own biases also influence the conclusions of the current research, as I am invested in providing evidence for the experiential constructivist diagnostic system. I do not mean to apologize for my position. Instead, I wish to highlight my perspective in attempt to be honest and reflexive about the project.

Criticisms of the DSM

I would like to present concerns I have regarding the DSM in the form of three interrelated criticisms: the questionable “empirical” basis of the DSM, the assumptions of the medical model that serve as the foundation for the DSM and the omission of issues related to meaning, purpose and richness. First, the empirical basis of the DSM, as described by its architects, is questionable. Some authors (Caplan, 1995; Kirk & Kutchins 1992; Kutchins & Kirk, 1997) have argued that the DSM is a product of political maneuvers, not hard science. Kirk & Kutchins (1992) document the substandard interrater reliability achieved in the field studies of the DSM. They argue that the DSM researchers’ focus on increasing reliability is a conscious attempt to quash discussion of validity (see also Sarbin, 1997). Kirk & Kutchins (1992) and Caplan (1995) also have discussed how empiricism gave way to political concerns in the exclusion or inclusion of certain diagnoses. The work of these authors critique the very foundation of the diagnostic system and raise certain questions as to the integrity of the DSM itself.

Second, the DSM is intricately tied to a medical model understanding of psychopathology. Leifer (1990) and Szasz (1960/2002) argued that the medical model and its therapeutics are forms of social control. In a similar fashion, other authors (Cushman, 1990, 2002; Farber, 1990, 1993; Hillman & Ventura, 1992; Laing, 1967; Levine, 2001) have suggested that the DSM and the medical model promote a specific type of normality that is in line with capitalist, American culture. As the tangible product of the medical model, the DSM is a powerful tool in promoting such a normality. Within this context, attempts to make the DSM appear atheoretical and empirically grounded are not surprising considering our culture’s
privileging of scientistic knowledge (Marcuse, 1964). As such, the DSM promotes the conflation of science with truth or science with reality. Instead, it may be more useful to understand science as ideology and examine the DSM as one construction of human pain and distress among many (Leitner & Faidley, 2002; Raskin & Lewandowski, 2000).

Lastly, persons’ attempts to deal with life’s most central questions often are disregarded in discussions of diagnosis. Theorists and researchers should take these concerns into account when offering alternatives (Leitner, 2005). Current understandings of persons continue to become increasingly narrow, as such conceptualizations reduce human pain to biological diseases. However, persons continue to wrestle with life’s most central questions, those regarding meaning, purpose and richness (Leitner & Phillips, 2003). The disregard for such issues may be the most dangerous aspect of mainstream, DSM-centered approaches to understanding psychopathology, as medicalized approaches ignore the value persons place on these central questions.

**Experiential Constructivism**

Experiential Constructivism, or EPCP, (Leitner, 1985) is an elaboration of Kelly’s (1955) Sociality and Choice corollaries. Kelly’s (1955) Sociality Corollary states “to the extent that one person construes the construction of another, [she or] he may play a role in a social process involving the other person” (p. 95). The Choice Corollary states, “a person chooses for [herself or] himself that alternative in a dichotomized construct through which [she or] he anticipates the greater possibility for extension and definition of [her or] his system” (p. 65). The Choice Corollary emphasizes the assumption that persons constantly strive to grow in their understanding of the world (Leitner, 1985). The Sociality Corollary, as it stresses the importance of the social world and interpersonal relations, is the most fundamental assumption of personal construct psychology and experiential constructivism (Leitner & Thomas, 2005). The task for constructivist psychologists, implied by these fundamental assumptions, is to understand how persons choose to limit or enrich their engagement with other persons.

There is a range in the intensity and importance of interpersonal relationships. Leitner (1985) writes, “people who construe my organization of my experiences in more depth will establish a more extensive ROLE relationship with me than those who construe me in less fundamental ways” (p. 85). Additionally, according to experiential constructivism, persons are constantly involved in a process of becoming. Thus, a true ROLE relationship must take into
account the constant motion of the other person and be open to change (Leitner, 1985, 1987; Leitner & Faidley, 1995). ROLE relationships have been defined (Kelly, 1955; Leitner, 1985) as the attempt to construe to the “construction process” of another person, instead of merely understanding the content of the constructs. In this sense, I may honor the construction process of another person only if I can respect another’s potential to change and grow and thus be willing to change my construing of that person. Leitner (1985) writes, “[I]f I change, you have to be willing to risk the threat of change also” (p. 85).

ROLE relationships can be the most enriching and the most terrifying experiences of contemporary life (Leitner, 1985; Leitner & Faidley, 1995; Leitner, Faidley & Celentana, 2000). In other words, when I allow one to understand my most central constructs I grant them access to the most essential components of my being. Thus, others have the potential to validate or invalidate the central aspects of my identity. In this manner, terror may accompany entries into ROLE relationships, as there is always the potential for crushing invalidation. Furthermore, the potential for validation does not minimize the potential terror associated with meaningful connection (Leitner & Faidley, 1995, p. 293). For instance, among other possibilities, such validation could lead to future risks, as validation will allow me to continue to open more central aspects of my being.

Psychopathology, from the perspective of experiential constructivism, may be conceptualized “in terms of how the person confronts the human dilemma of choosing between the richness yet potential terror of engaging in versus the safety yet emptiness of avoiding ROLE relationships” (Leitner & Faidley, 1995, p.293). Thus, one may choose to remain empty and numb (Leitner, 1999) or experience the full range of human emotion (e.g., the awe of validation and the terror of risk). Leitner (1999) writes:

Since intimacy is essential to affirm the richness of our humanity yet is filled with terror, we are all faced with a choice that is both exciting and threatening. Opening ourselves to human contact gives us a life of meaning yet potential terror. Retreating from such relationships makes us safe yet leaves us empty, isolated and alone. All of us then struggle with choosing some course between the terror and the safety, the richness and the emptiness, that determines the nature of our connections with others (p. 161). The purpose of psychotherapy then is to engage clients around this struggle (Leitner, 1988, 1999) of choosing richness versus emptiness.
**Experiential Constructivism and the DSM**

As experiential constructivism is interested in the ways that one retreats and enters into ROLE relationships (Leitner & Faidley, 2002), the decontextualized, symptom-oriented disorders of DSM diagnoses do not offer much in the way of conceptualization for the experiential constructivist therapist. Put simply, the label of “anxiety disorder” tells the therapist very little outside of the manifestation of one’s experience of anxiety. For instance, to the user of the DSM, a client’s feeling of anxiety may signify the presence of some “anxiety disorder,” indicating an intervention aimed at reducing this symptom. In contrast, the experiential constructivist would conceptualize symptoms of anxiety as a communication from the person, to the person, about the person (Leitner, Faidley & Celentana, 2000). Furthermore, the experiential constructivist would attempt to understand the communication in the service of fostering a ROLE relationship with the client. Additionally, therapists may use DSM diagnoses as a way to retreat from ROLE relationships, as the DSM focuses on “the construing of symptoms—not the construing of persons” (Leitner, 1985, p. 99). Using the previous example, if anxiety about one’s present and future is due to an early relational injury, the therapist would need to be able to hear the pain associated with the early wound. Often, such traumas (e.g., sexual abuse) are difficult for therapists to hear, and the DSM may provide some safety, as it ignores the role of such events.

Experiential constructivist researchers have documented how DSM diagnosis negatively impacts clients. Leitner (1985) describes a client that distrusted therapists due to past labeling by other professionals. This person, labeled with paranoid schizophrenia, believed that future clinicians would not believe her due to her “illness.” Therapists are given much power in the therapeutic relationship, as they are considered experts. Diagnoses and their implications are imbued with the same power. Thus, the client could take the diagnosis as reality and interact with self and other in ways that concretize the belief that she could not be trusted. For example, if I trust my therapist and believe in her construction that I am paranoid, I may begin to exist as if this construction were true.

Honos-Webb and Leitner (2001) systematically evaluated the damaging effects of DSM diagnosis in their case study of a client diagnosed with obsessive-compulsive disorder, generalized anxiety disorder, major depressive disorder, bipolar disorder, attention-deficit hyperactivity disorder, intermittent explosive disorder and paranoid personality disorder. Not
surprisingly, the client developed a construction of himself as “crazy.” The client’s limited understanding of his experience as “crazy” meant that he distrusted his own perceptions of reality and could not use them as a guide. For instance, he could not sense accurately when he was in a threatening situation as he always wondered whether his experience of fear as due to his being a paranoid personality disorder. Paralyzed by the effects of the diagnosis on trusting his experience, he could not engage the social world readily. Furthermore, the client became preoccupied with his problems and vulnerabilities, as the DSM’s focus on symptoms made it difficult to see his strengths. He could not create much of an understanding of himself beyond being “crazy” and “defective.”

The Experiential Constructivist Diagnostic System

While many construe non-mainstream approaches as being opposed to diagnosis and others have called for the abolishment of the practice (e.g. Szasz, 2002), diagnosis is an integral aspect of constructivist psychotherapy. Kelly (1955; see also Leitner & Faidley, 2002) conceptualized diagnosis, for constructivists, as the planning stage for psychotherapy. As psychology continues to increase its cadre of reductionistic approaches to comprehending and treating psychological struggles, persons still fight the alienation of modern life as they seek meaning, purpose and richness (Leitner & Phillips, 2003). Similarly, some mental health professionals continue to seek ways to conceptualize human pain in more respectful and useful ways. Experiential constructivism offers an explicitly valued understanding of psychopathology that includes the struggle for meaning in its approach to diagnosis.

Experiential constructivist diagnosis depends upon three interrelated components of a person’s meaning making system. These three axes are not intended to be independent of one another. Rather, they are three differing ways of understanding the same phenomena. First, experiential constructivism is interested in the ways early experiences affect how one construes self and other. The second component of diagnosis attempts to understand how one disperses her or his dependencies. The experiential components of relating are the final component of diagnosis (Leitner, Faidley, & Celentana, 2000; Leitner & Faidley, 2002; Leitner & Pfenninger, 1994). These nine experiential components (discrimination, flexibility, creativity, responsibility, openness, commitment, courage, forgiveness and reverence) are ways to experience the richness of existence.
Developmental Issues/Structural Arrests. Experiential constructivism conceptualizes trauma as experiences that are so threatening that meaning cannot be ascribed to it. In order to preserve the integrity of the meaning making system, traumatic experiences may be suspended in at a lower level of awareness, as their implications would be intolerable for the person (Leitner, 1999; Leitner, Faidley & Celentana, 2000). Experiences can be so traumatic that the person’s meaning-making system might become paralyzed. Experiential constructivist theorists have terms such early paralysis as a “structural arrest” (Leitner, 1997; Leitner, Faidley & Celentana, 2000). Often, structural arrests result from the overt and subtle traumas of childhood, when it is more difficult to incorporate traumatic experiences into one’s meaning making system. As early experiences also form our basic construction of self and other, structural arrests may have negative effects on one’s ability to be intimate with other persons. When structural arrests occur, the process of differentiating the self from others is hindered. Without a basic construction of the self versus other, the world is chaotic, as one cannot separate the self from others.

The notions of self-other permanence and self-other constancy help to elucidate the effects of these arrests (Leitner, Faidley & Celentana, 2000). Early structural arrests may result in struggles with self-other permanence—the ability to know and count on the existence of others even when they are separated from us. Without a sense of permanence of self and other, it becomes impossible to maintain relationships over time, as relationships involve both connection and separation. For instance, if I struggle with permanence, I may have an experiential world where, when the other is psychologically or physically absent, it is as if the other ceases to exist. A lack of self-permanence also could result in the experiential disappearance of the self as the other enters awareness. Feelings of abandonment and terror often accompany struggles with self-other permanence, as one’s experiential world is chaotic and fragmentary because the existence of others cannot be trusted.

Self-other constancy is a step beyond permanence in that constancy involves the ability to integrate new constructions of self and other into a coherent sense of identity. For instance, during times of validation, one may experience the other as connected and inspirational. However, during times of disagreement, one experiences the partner as rejecting and destructive. In other words, a person may have difficulty integrating the complexity of another person coherently; it is experientially like different people at different times. Such a struggle with
constancy would limit the depth of this relationship, as anger cannot be admitted to in the relationship.

**Interpersonal Components.** Rather than construing persons as dependent or independent, experiential constructivism focuses on how persons manage or disperse their dependencies. In addition, persons may distance themselves from others in literal, physical manners or in more psychological ways. The interpersonal components axis of the experiential constructivist diagnostic system attempts to capture such issues.

Persons may struggle with relating by underdispersing their dependencies. Such persons allow very few others to affirm or disconfirm them (Kelly, 1955; Walker, 1993). In some respects, underdispersion may keep a person safe from the terror that accompanies entering into relationships, but invalidation and/or abandonment by one of the few persons being depended upon may lead to crisis. On the other hand, persons may struggle by relating through excessively dispersing dependencies. Such persons allow many others to confirm or disconfirm their cores. One also may experience emptiness in this situation because there is an inability to construe the other as a full person, as others often are objects that serve to affirm the person’s existence. In addition, persons who overdisperser their dependencies frequently experience the profound invalidation of their core as they often attempt to share their most vital meanings with people who are likely to injure them. Persons also may struggle with relating by avoiding all or most dependencies. For such persons, others have little effect on their meaning making systems.

Experiential constructivism understands the ways people distance themselves from ROLE relationships on two levels (Leitner, 1988; Leitner & Faidley, 2002; Leitner, Faidley & Celentana, 2000). First, persons may physically distance themselves from ROLE relationships. A person moving to another area in order to flee a ROLE relationship is an overt example of physical distancing. People often physically distance themselves while maintaining the semblance of a relationship. People may find reasons (e.g., long hours at work) to excuse being absent for long periods of time. More commonly, persons psychologically distance themselves from others, again while maintaining the façade of a relationship. For example, one may psychologically distance oneself from another by construing the other only as fulfilling certain needs. When a person ceases to experience joy or happiness when relating to another, “[t]he other is nothing more than a collection of drives, attitudes, and behaviors, and one’s relationship is little more than a set of activities” (Leitner, Faidley & Celentana, 2000, p. 187).
**Experiential Components.** Leitner and Pfenninger (1994) described optimal functioning in terms of nine interrelated experiential components that can be seen as elaborations of empathy (Leitner & Pfenninger, 1994; Leitner & Faidley, 2002; Leitner, Faidley & Celentana, 2000). First, because others have the potential to invalidate core aspects of my being, I must exercise some caution when entering into relationships. **Discrimination** involves the ability to see the other as a separate person and evaluate how two meaning making systems will affect one another. Because two persons have different constructions of the world, I must understand that some people will be unable to affirm my core. Without discriminating, I open myself to profound invalidation.

People may struggle with over-discriminating or under-discriminating. Persons may struggle by over-discriminating and avoid relationships altogether, as the felt potential for invalidation is too great. People may use any difference in the other person as a justification for ending the relationship. While I may be able to initiate relationships, terror may eventually lead to avoiding greater intimacy, as the relationship deepens and there is more potential for invalidation. On the other hand, I may struggle by under-discriminating. For instance, I may reveal key aspects of my being to anyone regardless of their potential to invalidate me. I may indiscriminately disclose intimate experiences, often resulting in my feeling devastated, as not everyone can affirm my core.

The entrance into relationships is augmented by personal **flexibility.** Flexibility involves the ability to construe alternative constructions. In other words, to enter into a relationship with you, I must be able to be flexible enough to try to see the world from where you are standing (Faidley, 2001). While important at the beginning of relationships, flexibility is necessary throughout a relationship. In order to have a ROLE relationship with another person, I must be able to reconstrue the other as the relationship deepens. Without such flexibility, the relationship may become stagnant. (e.g., “Our relationships is stuck, isn’t moving forward, etc.”). Additionally, I may be too flexible by frequently accommodating the other to the detriment of my needs. Thus, flexibility is the ability to hold my meanings along with those of the other in my awareness.

I must have the ability to be creative as a ROLE relationship deepens, as I must have the “ability to develop new ways of understanding the mysterious other” (Leitner & Pfenninger, 1994, p. 123). **Creativity,** in this sense, is the ability to accept the constructions of others and
allow them to revise my own meaning making system. Creativity, according to Kelly (1955), involves a cycle of moving between loosening and tightening of the construing process. At the beginning of this cycle, I allow my construct system to loosen or become less precise. This lack of precision provides “the fertile chaos necessary for reinventing the other” (Leitner & Pfenninger, 1994, p. 125). The end of this cycle involves tightening and making revised constructs more precise by testing their implications in the world. Being creative in my constructs of others allows me to understand another person as an evolving process. People may struggle at any point in this cycle. While a difficulty in loosening my constructs may not allow me to experience the fertile chaos that brings vitality to relationships, struggles with tightening my constructs may not allow me to test my newfound or revised constructs in the world.

One’s ability to be creative in relationships involves acknowledging that two people co-construct a relationship. Persons must be willing to take responsibility and examine their meaning-making system and its implications for others (Leitner & Pfenninger, 1994; Leitner & Faidley, 2002; Leitner, Faidley & Celentana, 2000). Experiential constructivism assumes that meaning is created in relationships. Thus, there are some ways the person is responsible for the meanings he or she creates. There are also ways that context plays a role in the creation of these meanings. As both partners have created the relationship, they also must take the appropriate amount of responsibility for the relationship and the meanings created within it. For instance, I may avoid taking the responsibility necessary in a ROLE relationship by placing responsibility on the other person, especially when I have harmed the other or the relationship. I could further avoid responsibility by construing my actions as based on factors or events outside of my control (e.g. upbringing, genes, biochemistry, etc.). However, being responsible entails that I openly look at the meanings I have created and accept that there are a variety of ways to construe my actions.

On the other hand, instead of avoiding responsibility, I may assume an excessive amount of responsibility. I may attribute the failure of a relationship only to myself as opposed to examining how the other also affects the relationship. The optimally functioning person understands the person-environment interaction. Taking responsibility allows for me to evaluate my own position in the world in order to “come to grips with [my] own teleological capacities as a causal (and, hence, responsible) agent” (Leitner & Pfenninger, 1994, p. 127).
As ROLE relationships necessitate mutuality, openness is understood as the willingness to reconstrue when invalidated (Leitner & Pfenninger, 1994). I must be open to the possibility of invalidation when beginning a relationship, as I cannot know the other directly. The other is never encompassed fully by the meanings I have created to understand him or her. In this manner, the constructions I have of the other will, in time, be invalidated. At this point, I am faced with a choice: (1) I can choose to maintain my constructions of the other; (2) I can leave constructions behind and create entirely new ones; (3) I can modify or revise my preexisting constructions of the other. EPCP defines openness in terms of the person’s negotiation of these choices when invalidated. For instance, I may construe a partner as solely supportive and a source of strength. As the partner cannot live up to such an understanding, he or she will eventually invalidate me by not being supportive at some point. I can choose to cling to old constructions of the other that may not be particularly useful and become angry with the other for not supporting me. Kelly (1955) considered such anger a form of hostility. Kelly (1955) defined hostility as forcing others to provide validation of constructs that have lost their utility. Thus, my expression of anger is an insistence that the other be the way I want them to be.

Conversely, I can modify my understanding of the other: the other can be a source of support but fallible. Openness does not imply that I always should change my constructions of the other. I may be too willing to reconstrue when invalidated. For instance, I may invalidate my core meanings to hold another’s meanings in awareness. As ROLE relationships involve sharing my core meanings with another, excessive openness may hinder this process.

Commitment is defined as the willingness to affirm the other’s process over time. If a ROLE relationship is to become rich and vital, persons must commit to experiencing and affirming the other’s process over time. For instance, while I may able to initiate relationships quite well, I may have trouble committing to another over time and, as a result, the other then may have difficulty trusting my ability to be present. During times of difficulties, I may be too willing to end the relationship or I may retreat and resign myself to a much less intimate relationship. If I am struggling with over-commitment, I may find it difficult to end a troublesome relationship. While the other has ceased to affirm my existence, I may find it difficult to understand that it may be healthy and appropriate to end the relationship than remain in a relationship that has little impact or meaning for me.
Leitner and Pfenninger (1994) define courage as the willingness to be involved in a ROLE relationship despite the potential for invalidation and pain. Courage involves the awareness that invalidation will occur when intensely relating to another. I may struggle with courage in that safety may be a primary concern. Thus, I shelter myself from the terror, fear or vulnerability of relating. On the other hand, I may choose to deny or minimize the fear of interpersonal relating. Because I ward off the experience of fear, it may be difficult for me to participate fully in the co-construction of a meaningful relationship (Leitner, Faidley & Celentana, 2000). Therefore, I must have enough of an understanding of my constructions to fully experience the validation and invalidations inherent in ROLE relationships. Thus, courage also involves having a clear or working conceptualization of my own core constructs (Leitner & Pfenninger, 1994).

Forgiveness builds upon the constructs of openness, flexibility, responsibility and courage in that one must be able to reconstrue when invalidated in order to continue relating to another. Forgiveness, in experiential constructivist terms, overlaps with the colloquial definition of forgiveness. It should be noted that the experiential constructivist notion of forgiveness does not necessarily mean that I reconnect with the relational partner who has injured me. Experiential constructivism emphasizes the ability to continue to relate meaningfully with others in the face of past invalidations. Invalidations are a common experience and all persons must find ways of accepting pain of past injuries and risking with others in the future. Thus, one should not forget that one was invalidated. Instead, forgiveness implies that one reconstrues his or her own core constructs as well as those of the other. In other words, I do not allow past relational injuries to circumvent meaningful relating in the present. If I allow a past injury to generalize to all my relationships, I may see most everyone as potentially dangerous. On the other hand, if I forgive the other in quick and haphazard manner, I may not fully understand or experience the pain of a current relational injury. By not acknowledging this pain, I do not allow for the relationship to deepen.

Reverence is the understanding that one is validating the core ROLE constructs of another person. I experientially understand and appreciate the other’s openness and courage in entering into a relationship with me. I value both the acceptance and the retreat from ROLE relationships. In other words, the person sees the other as a whole person; a person that is vulnerable and fallible as well as courageous. Leitner and Faidley (1995) describe reverence in
terms of the feeling of awe. Reverence is similar to Buber’s (1923/1958) discussion of I-thou experiences. Reverence is the ultimate experience of ecstasy in a ROLE relationship and, diagnostically, would imply an optimally functioning person.

Thus, the experiential constructivist diagnostic system is a theoretically based alternative to the DSM. In the present study, I will ask clients to compare experiential constructivist and DSM diagnoses. In addition, the study will be the first systematic investigation of the experiential constructivist diagnostic system. Experiential constructivist scholars can use participants’ experience of the experiential constructivist diagnostic system to continue developing the system and provide avenues for future research. While the research is useful to experiential constructivists, clients’ experiences of diagnoses may helpful to other professionals who struggle to find more respectful and useful ways to diagnose human pain and distress.

Method

Participants

I recruited four clients from a state hospital. (See the Results section for specific demographic information.) Each participant gave informed consent (Appendix A). At the conclusion of the study, I explained the purpose of the study and debriefed each participant (Appendix B).

Procedure and Materials

Diagnosing. Initially, I engaged in a diagnostic interview with each client in order to construct an experiential constructivist diagnosis. In most cases, I began the diagnostic interview by simply asking the clients to tell me what I would need to know to understand them. Each of the diagnostic interviews lasted for approximately 90 minutes. A team of therapists (diagnosis group) who had experience with the experiential constructivist diagnostic system then assisted constructing the diagnosis from the audiotape of each interview. After listening to the tapes with the group, I wrote an experiential constructivist diagnosis for each participant. I then gave the experiential constructivist diagnosis back to the diagnosis group for revisions and confirmation. The diagnosis took the form of a narrative describing the participants’ struggles along all three axes.

I took participants’ DSM diagnoses from their charts at the hospital and confirmed them with the diagnosis group while listening to the diagnostic interview. I presented participants with a description of their DSM diagnosis without the diagnostic label. I attempted to use as
much of the language of the DSM when writing these diagnosis. In all cases, I used the person’s primary diagnosis. For instance, while three of our participants also were diagnosed with substance abuse or dependence, I only described the primary diagnosis. After I wrote each participant’s DSM diagnosis, the diagnosis group provided feedback and any necessary revisions.

Because I did not want to present participants with more than ten pages of written description, I abbreviated certain DSM diagnoses (e.g., schizophrenia). I distilled the essential components of each diagnosis in four to five pages. For instance, I omitted any information that was very far from a client’s experience (e.g., differential diagnosis, laboratory findings). I also replaced any information that mentioned the actual name of the disorder with phrases like “such struggles.” For example, the phrase “individuals with schizophrenia” was changed to “individuals with such struggles.” Finally, I altered some of the language of the DSM to facilitate comprehensions (e.g., placing the word “emotions” in parenthesis after the mention of “affects”). However, I used as much of the language of the DSM as possible.

I also wrote the experiential constructivist diagnoses in an idiographic fashion and the DSM diagnoses in a nomothetic fashion. As experiential constructivist diagnoses are not meant to categorize human experience, they are necessarily idiographic and idiosyncratic. Thus, I used personal information throughout the diagnosis. An experiential constructivist diagnosis cannot speak of structural arrests with some statement regarding the nature of these struggles. For instance, one participant’s struggles with permanence did not allow him to access those parts of himself that were open and accepting of others when he felt as though he was an angry and destructive person. Another participant’s struggles with permanence made it difficult for him to have a solid enough perspective of the world to feel stable and alive. Thus, permanence struggles manifest themselves in a variety of ways and the experiential constructivist diagnosis must take into account the content and process of a person’s experience.

DSM diagnoses are explicitly nomothetic and are intended to apply to a number of persons. Thus, I wanted to preserve this aspect of the diagnosis and decided that tailoring each diagnosis to each person would change the actual diagnosis itself. For instance, it is possible to diagnose a person with schizophrenia even if he or she did not experience negative symptoms (Criterion A5). From my observations, if a client with this constellation of symptoms was withdrawn, sad or unusually quiet on a particular day, his or her behaviors where attributed to the
diagnosis and labeled as negative symptoms. Because the DSM is built on the assumptions of the medical model, symptoms may lie dormant for a period of time and may manifest themselves at other times. I felt that if I tailored each diagnosis to each participant’s unique expression of symptoms, then the symptom-focused, disease model of the DSM would be obscured. I could have included personal information (i.e., the content of hallucinations), but I believe it would have detracted from the categorical nature of the system. While I could have made different choices, each would have affected the research process in a variety of ways. Simply stated, the findings should be understood in the context of a variety of choices, implicit and explicit, that I made during the construction of the diagnoses.

**Presentation to Participants.** Once both diagnoses were constructed, I conducted a second, semi-structured research interview with the participants (Appendix C). In two cases, the second interview was divided over a number of sessions. During the research interview, I gave the participants both their DSM and experiential constructivist diagnostic conceptualizations. I constructed a semi-structured interview for the research interview. I divided the interview into four categories: (1) general understandings of diagnosis, (2) how the participant experienced each diagnostic scheme, (3) how the participant believed a therapist using each diagnostic scheme would construe his or her struggles, (4) perceptions of the client-therapist relationship.

I structured the interview such that we moved from broader themes to more specific issues. The first category, general understandings of diagnosis, participants described how they understood psychological struggles. With the second category of questions, I explored participants’ perceptions of their struggles in relation to each diagnostic scheme. Specifically, I asked participants to describe reactions to and perception of each conceptualization, preference, assessment of strengths and weaknesses and each conceptualization’s implications for change. For example, I asked participants to describe how each conceptualization captured their strengths and weaknesses.

In the third category of questions, I explored participants’ perceptions of a therapist in relation to each diagnostic scheme. Put differently, I attempted to understand how participants’ perceptions of their therapists are mediated by the conceptualization used by the therapist. For instance, I asked each participant to imagine a therapist where the only information the participant knew about this imaginal therapist was that she or he used either the DSM or experiential constructivist diagnosis. With the final set of questions, I assessed participants’
perceptions of the client-therapist relationship in relation to each diagnostic scheme. For example, participants explored how their ability to trust a therapist would change in relation to each diagnostic scheme.

Specifically, the interview began when I asked the first category of questions concerning general notions of psychological struggles. Participants then read one of the two diagnoses (Note: two participants read the experiential constructivist diagnosis first; two participants read the DSM diagnosis first). After they had read the first diagnosis, I asked participants if they needed clarification of any concepts or verbiage. Before beginning the final three sections of the interview, I asked participants for their initial impressions of the diagnosis. When the interview questions and discussion were exhausted, participants read the second diagnosis and answered the same questions. Following the interview about the second diagnostic categorization, I asked clients to compare the diagnoses and provide any final thoughts that were not captured by the interview. At the conclusion of the interview, I gave participants the opportunity to ask any questions they might have had concerning the research.

Analysis. I used two approaches to qualitative analysis: phenomenology (Giorgi, 1975; Fischer & Wertz, 1979) and symbolic interactionism (Denzin, 1995, 2001), as articulated by Smith (1995) and Smith, Jarman and Osborn (1999) in their interpretive phenomenological analysis. In the analysis, I sought insight into the various ways participants’ construed the experiential constructivist and DSM diagnoses. However, as the act of diagnosis takes place within a cultural, social and political milieu, reactions to these diagnoses cannot be understood as isolated from these contexts. Thus, I believed these two approaches were the most appropriate method of analysis.

Phenomenology holds that much of our preconceived, scientific, and causal conceptions of phenomena must be replaced with descriptive understandings that do not serve to explain causal events (see Giorgi, 1970, 1995). Instead, the researcher aims to highlight the event or phenomenon in itself. In order to accomplish this goal, phenomenological researchers depend upon phenomenological reduction. First, phenomenological reduction is the “suspension of judgment as to the existence or non-existence of a content of an experience” (Kvale, 1983, p. 184). The researcher attempts to nullify the natural attitude that biases all perception. It is important to note that a complete reduction or nullification is impossible. Thus, the researcher must interrogate her or his beliefs and preconceptions in order to monitor the effects on
interpretation. There is also a deliberateness to phenomenological research (Wertz, 1983). Deliberateness involves empathically immersing oneself within the subjective experience of another person. In this type of analysis, there is no minutia or generalization; all details must be magnified in order to immerse oneself in the experience of another.

I also employed the notions of thick description and thick interpretation (Denzin, 2001). Thick description does not gloss over lived experience for academic jargon or abstractions; instead, “thick description creates verisimilitude—that is, the realistic description produces for readers the feeling that they have described” (Denzin, 2001, p. 100). Furthermore, thick description involves a rich understanding of both subjective experience and the interplay between persons and society. Thick interpretation follows from thick description. In line with thick description and interpretation and the premises of phenomenology, I have provided detailed descriptions of the interviews as the results of this project. For each participant, I have provided a narrative of the interviews. I offered my own thoughts, feelings and interpretations interspersed through these narratives in order to immerse the reader in my experience of the interviews. The detailed descriptions of the interview also allow the reader to understand how I came to my interpretations and conclusions. As interactionism studies “the intersections of interaction, biography, and social structure in particular historical moments” (Denzin, 1995, p. 57), it added a crucial component to the phenomenological study of subjective experience by understanding the interplay of personal and social meanings.

Results

Before presenting the results, I would like to provide the reader with a structure to understand the following sections. As the results are organized as detailed descriptions of interview, the text includes four distinct voices. First, the participants’ voices are present. Second, my voice at the time of the interviews is included in the results. Third, my experience with the participants, including thoughts, feelings and interpretation, are active in the document. Fourth, the text includes the interpretations I made during the analysis of the data. For stylistic reasons and coherence, I presented the interpretations I made while analyzing the data and my experience in the room without any distinction. I have italicized my later interpretations in order to distinguish these thoughts from my experience during the interview. The voice of my participants at the time of the interview and my voice at the time of the interview are in quotation marks.
Simon

Simon was a 33 year old, African-American male who had spent the last 15 years homeless or in and out of a variety of inpatient facilities. Simon spent the last three years at the facility in which we met, originally admitted due to concern over his potential to do harm to others. According to Simon, the last straw with his doctor was getting into two fights with two different correctional officers. Two of these three years were spent drugged with muscle relaxants and antipsychotic drugs. When we had met, however, Simon had been progressing through the hospital’s program successfully and was preparing to be discharged.

Simon and I met for two intake interviews. The first lasted about an hour. I will focus on this interview, as the research group had enough information to formulate an experiential constructivist diagnosis after listening to the first interview. The research group did not listen to the second interview and it only provides background information and further confirmation of our original diagnosis. We discussed the diagnoses over three different research interviews. In total, Simon and I were able to meet once a week for five weeks. Simon described his experience in complex and poetic ways and the extra time was useful for me to understand his experience more fully. Further, the extra meetings gave me a sense of how the diagnoses continued to be construed over time.

Diagnostic Interview. Upon meeting Simon for our first interview, I had the sense he was excited to begin the interview process, as he responded to my invitation to tell me about himself with a request for paper to take personal notes. As I would learn later, Simon took self-reflection seriously. After handing him some paper from a stack on the desk, I asked Simon where he would like to start. He responded, “Uhm, I don’t know. I’ll be 33 this year. Hmm, I don’t know. I guess—I don’t know—I guess, I’m 33, been in college, I’ve been sleepin’ on the streets, you know, so, I don’t know. I’ve seen a lot. I kinda grew up pretty much middle class, you know. My family, we probably were above the poverty line, but we stayed in the inner city, so, I’ve seen, I’ve seen federal agents raidin’ my neighbor’s house for drugs. You know, I’ve seen that. I’ve been friends with people that’s been friends with people, known people, that’s got killed, no one really myself. But, I’ve had a few of my neighbors, a girl I used to talk to, her boyfriend got killed. Had a cousin that I didn’t know too well—he got killed—back in the 90s. I pretty much didn’t get too involved in the like street life ‘cause I had both of my parents, so I couldn’t really run with wild kids.” Not only are killings, death and police raids
difficult enough to experience, but I was struck that Simon chose to tell me about death and loss first. I silently wondered how Simon experienced these losses.

Simon’s last statement about this parents piqued my curiosity and I asked him what he meant by “couldn’t.” Simon responded, “I had a structure. I had to be home at a certain time. My parents had to know where I was at all times. So, I never really had the opportunity to do too much hell raisin’ as a juvenile. Had a pretty close-knit family I guess I would say. I didn’t do too much.” Moving from his parents back to the neighborhood, we discussed how he seemed to miss many of these features as a younger child and didn’t notice some of the troubles until he was older. He offered the possibility that he was “homebody.”

I said, “So, you stayed with yourself most of the time.”

Simon smiled briefly and responded, “I guess my family was enough of a mystery for me not to have to go out and search for the unknown in other places, you know. My own family was kinda mysterious, so it was enough of a job to try to figure out who I was in relationship with my family.” This was curious to me because I thought his family offered structure and, possibly, protection from the violence of neighborhood. It seemed, however, that his family offered a physical presence but remained mysterious and vague to him.

I offered this understanding to Simon and he responded, “Yeah, big mystery. And, my mom, my mom, she is diagnosed as a bipolar, probably in like the early eighties. She probably had her first nervous breakdown after my brother was born in the late 70s. And, I kinda remember, I remember she was, she was really into the church. So—people would come by from the church and try to encourage her to—I guess you would say minister to her, to kinda help her get back into whatever she was supposed to be doing, you know. But, ahh, my mother, I guess, she didn’t know her father. Her mother remarried, and she never really had a relationship with her father. And, her father’s family kinda disowned her, so she didn’t have a real father figure in her family. And, she met my dad. They were probably about 17 or something like that. She was, I think she was kinda, running from her family. She didn’t, she wasn’t happy with the situation there because everyone was drinkers and partiers, and she became the model housewife. I mean she had a job, but she made sure we were in church you know and that sort of thing. And, she really kinda, her siblings, she didn’t really have too much to deal with them. And, I don’t know, I kinda think back, they say she is bipolar, so they say that she has ups and downs,
like manic episodes. And, so, when she had her manic episodes she’d be like—she’d start to drink and she would go on spending sprees and things like that.”

Simon paused for a few moments, reflecting upon his mother at these times. He smiled broadly and continued, “I enjoyed the liveliness in the household. I mean, I enjoyed the chaos, kinda, you know. ‘Cause I felt like that was really my mother; I felt like she was more herself. I mean, the spending, I guess that is a characteristic of bipolars how they, when they get manic they feel like they’re incredibly wealthy or something like that. But, that’s not just limited to bipolars, but, it just felt like she was alive—she wasn’t just, you know, a ghost, you know. Just born to work and come home and cook. She had opinions and she had ideas and she had likes and dislikes. And you could see her, really in her, in her elements. I always secretly wished that she would get stuck in the manic cycle. You know, cause I felt like that was her true self, you know.”

At these times, his mother felt more real to him. Instead of stifling her emotions, Susan, Simon’s mother, would express her inner life to Simon, something that was an anomaly in his experience. When his mother was not “manic,” she felt dead to Simon, a phantom whose presence was fleeting and vague. Not only were these times preferable to his mother stifling her emotions, Simon would secretly wish his mother would “get stuck” in the mania. Simon continued that his mother often would be hospitalized during the periods of mania. For Simon, his mother’s presence or appearance would rekindle this wish for her to remain, only for her to be physically removed from the household and hospitalized. In other words, when he felt connected to his mother, she would physically disappear. At these times, “we [Simon, his father and brother] would kinda be hurtin’…if she was out of whack, if she wasn’t in the picture, we were out of whack.” Simon’s father did not seem to be a strong source of support at these times, as he also came from a turbulent upbringing.

Simon described his experience at these times as fractured. He said, “It just was, I mean, you’ve got Hindu gods, you know what I’m sayin’, that had a lot of faces, you know what I’m sayin’, Hindu deities and it was like, when these things were happening you’d get to see other faces, your faces. So, instead of just being Simon the son, you know what I’m sayin’, it’d be like, Simon the son of Susan. You and it would be another, I’d be able to look at myself, from a different angle…I think we kinda were pushed in these little conforming boxes that never seemed to fit us. So, when these episodes would come up we would get to see other sides of our
universe, you know. And, so, I always enjoyed that, you know, ‘cause I never really knew who I was, you know, in relationship to my family or to my community. So, you know, I knew I was a first grader, you know, I had to do my homework, but none of it never really clicked for me, you know. I mean I did alright in school, but, it never, it just was a task, it wasn’t something I enjoyed doing. I think I kinda picked that up from my mother and my father really. They worked…[but] I don’t know if they really enjoyed what they were doing. So, I think that…reflected on my attitude to my schoolwork, you know, I was just a student, I was just there, you know, doing my eight hours, you know…I remember when I was probably five or six, we—it was the summertime, I think my uncle or somebody had got me a football and maybe a basketball or something like that. And, I just remember I was outside of the apartment and I, just for some reason, I began to be depressed, you know. And, I remember I was depressed as like a five year old kid, you know, where I wouldn’t go outside, I would just lay in my parents’ room—it was the only room in the whole apartment that had an air conditioner—so, I remember not going outside and just laying on the floor of my parent’s room just kinda depressed, you know. So, I don’t know, maybe I’ve been depressed, I think I have been depressed for most of my life, you know what I mean, and I think it didn’t catch up with me until I became a man, you know, when I was 16, 17, 18.”

Simon continued to describe the difficulties he had connecting with his parents in relation to establishing a solid sense of self. Constructing a solid sense of self and other was especially difficult, as his parents were not able to give him the support he needed. He said, “I always kinda felt like I had a purpose in life, but I didn’t have the assets to really go out and do what I felt like it was my duty to do, you know. I didn’t have the extra hands, I didn’t have the help, I didn’t have the support group, you know. So, it’s like, I was, I was fastening my place in the universe with the sweat of my own brow.”

Again, he referenced his parent’s attempts to keep the appearance of a perfect family and said, “I think they were busy trying to keep like images of the perfect family. They were trying to hold it together, so they didn’t have time with the kids, you know, ‘cause it was a full job for them just to keep their image going. So, they’d be beat by the time it came to deal with us. I mean we had the four walls of the house to protect us from the negative elements outside, but, maybe ghosts, or something, you know, became my friends or my leaders, you know. And, these

21
ghosts, you know, they were already in house, you know, so, I don’t know. I think that is where I got most of my discipline—from these ghosts, I guess.”

“Can you say more about these ghosts?” I asked.

“[These ghosts were the products of] two dysfunctional families, you know, and so my dad he left his family and took on the role of breadwinner for the household. My mom left her dysfunctional family and became like the mother, you know. She was kinda like the lawgiver,” Simon punctuated this last sentence with laughter and continued, “So, they put on this porcelain image of the family, but the reality that they came from was not dealt with in a healthy way, so it was passed down to us. Maybe not directly, but indirectly, so when they were off doing their image-keeping other elements began to creep in. And, these are the forces that kinda shaped me from my youth and to now and they still influencin’ me, you know,” Simon responded.

I was confused as to the nature of these ghosts. While his parents were attempting to flee their own pasts and don porcelain masks that would seem to allow them to enter mainstream culture, these ghosts had influenced and disciplined him. Simon’s choice of white, porcelain masks is important, as he was keenly aware of his position in the world as an African-American male inpatient. It appeared as though Simon thought his parents lost their cultural and racial history by wearing these masks. Furthermore, because of these masks, his parents felt like ghosts when they were psychologically unavailable to him. While Simon described these ghosts with both a positive and negative valence throughout our time together, I often wondered about the depth of Simon’s aloneness. Simon and I never discussed the physical and emotional abuses of his childhood directly and I wondered if these ghosts represented parts of his parents that he could not understand as a young child or as an adult. Additionally, Simon’s descriptions of ghosts left me with a feeling of incredible aloneness, as these ghosts were more significant than other persons in his life.

The conversation about ghosts led to Simon describing one of his most central dilemmas. Simon had trouble integrating the different values and philosophies that his parents utilized to understand their lives. He characterized his father by his interests, mainly in music and studies in spirituality, namely Eastern religions. He described his path as being similar to his father’s, as Eastern philosophies have helped him make sense of himself. For his mother, this path was unacceptable, as “secular” music (e.g., Bob Marley and Jimi Hendrix) and Eastern religions were not appropriate for the image of the perfect family. Furthermore, for Susan, Christianity and its
teachings were “the center place of the household.” He seemed to find it difficult to integrate these two aspects of his parents.

I asked him how integrating his parents’ perspectives caught up with him when he became a man. Simon paused and responded, “When I became a man, it was kinda like a clashing of the two ideas. I kinda think I, I don’t know if I made a successful transition or I found a comfortable spot for both of them. So, I didn’t deny my mother’s upbringing and I didn’t deny my dad’s influence. I kinda found a center point, which allowed both of them to flourish, you know. So, I mean, I am listenin’ to Bob Marley and he is talking about God and Jesus and heaven and all these ideas that I heard as a kid with my Mom and at the same time he is talking about revolution and change and he is smokin’ ganja, you know. I remember my dad, those smells, the herb, I remember them as a kid. So, I figure I have both of them. I have my mom and my dad, so I leave the house hugging both of the idols [makes a motion like has two people in headlocks], you know, I’ve got God in one arm and I got my Dad in the other arm. So, I figure if I can’t exist in their house with both of them, then it is best for me to leave, you know, so I take ‘em and I try to uproot them and plant them so I can have the best of both worlds, so I can eat those fruit and be, experience life as I know it, ‘cause it was clashing too much in the house, so I had to take ‘em and leave, so I left.” Simon struggled in replanting, or incorporating, these two worldviews. Simon’s headlock motion was very telling. Not only did he have to “sneak and take them,” but also there was great tension using these differing constructions of the world.

Simon puts his struggle best when he offered this imaginary dialogue between him and his mother: “‘What’s that over there [father’s values and idols]?’ ‘That’s not God, you don’t want to deal with that, that’s evil, that’s bad.’ ‘Well, why is Dad doing it?’” At this point, his father’s values and possible inheritances were pitted against God, a difficult position for any father to be placed. Simon continued, “I had to wrestle with this and I had to come to grips with it on my own and I think that is were I am right now. I’m still trying to hold both of them and I can’t put them down because they both have weight in the universe, you know. I don’t wanna lose ‘em, but I may have to cut my losses, you know, because if I can’t get a direct current from my parents, it’s like adultery. It’s like, if I’m not getting it directly from them, it’s tainted because I have to steal it. And anything that you steal, you know, it’s not good, you know, theft is not good, you know. So, if I can’t get it directly from them, I’m going to have to let ‘em go or
it is going to destroy me. I think I just came to that conclusion now [laughs]. Yeah, so, I don’t know, I don’t want to give them up, you know, ‘cause I think they are part of me, but I don’t wanna be in and out of places like this for the rest of my life. I don’t wanna be talkin’ to, I wanna talk to my parents about these things, you know, I want to be able to say, ‘Hey! Here I am. These are the things that I took from you guys. These are the things you gave me, let’s straighten it out before something else happens, before somebody else dies, and their life is incomplete and they become a ghost, you know.’ And, then, the ghosts influence another generation, and another generation is lost to the system, you know. ‘Let’s try to straighten this out and get back on the trail, so we can continue on, you know, instead of being lost.’”

Simon struggled to integrate his parents’ different ways of being in a way that felt comfortable and stable for him. Furthermore, it is clear that Simon understands his institutionalizations in relation to the struggle to feel solid and stable. Additionally, I began to understand the role of the ghosts a bit more; when family members’ lives remain incomplete, their ghosts haunt their descendants. Thus, one person’s struggles are passed down through the generations. At this point, ghosts seem to represent those parts of his parents that he could not understand as well as the metaphorical intergenerational “skeletons in the closet.”

Another important aspect of Simon’s description of his place in the world was the stress he put on having a dialogue with his parents. He worried that if he continued to have conversations like the one we were having, dialogues that happened outside of his family, healing could not occur. He felt our time could have been better spent “on a beach somewhere having margaritas” rather than in an institution. For Simon, he needed to direct his energies back to their origin. He said, “It’s kinda like in alchemy, there’s this, ahh, I guess you would call it a teaching, where the salamander eats its tail…It made some type of healing balm or something like that, when it regurgitated its tail. And, it was a healing salve that could be used and so—I need, I need that, you know what I’m saying. So, I guess this is all me trying to project my energy back into their direction.”

Simon continued, “I need that [the healing salve], you know what I’m saying. So, I guess this is all me trying to project my energy back into their direction. It’s like me crying as a baby, you know what I’m sayin’, trying to get my parents’ attention, you know, and that’s probably all this whole schizophrenic thing is, you know, it’s a child’s trying to get his parent’s attention, you know, trying to say, ‘Hey! I’m over here, you left me over here, I haven’t been fed, I haven’t
been cleansed, I haven’t been changed.’ And, they’re, they’re off doing their thing. And, I have to keep my eyes on what they are doing now cause, eventually, if they come and get me, then I have to see where they were when I was in my uncared for state and have to see where they were, so I can learn from them that position too. It just makes our whole relationship stronger, it makes our bond tighter and makes us healthier, so we can weather the elements, you know, we can be successful.” The healing salve Simon desired was a conversation with his family that would allow everyone to see each other’s perspective. I agreed with Simon’s discussion of schizophrenia as well as the notion that conversations with his parents would allow him to heal. But, I also had a feeling of despair and realized what Simon craved would never come to fruition. The chance that everyone could come together and reflect upon their lives, in the way Simon hoped, seemed unlikely. Additionally, it appeared that Simon’s remarkable acumen and intelligence hid considerable pain and early relational injuries.

Simon continued to describe how he feels fractured in relation to these ghosts. Because they played a more prominent role in his life than his parents, he described existing “in between these other realities, other ideas, these other notions, these other ghosts, so I haven’t been able to experience myself in my totality, you know, I’ve always been fractured... I mean, I think it is a proverb or a psalm of David, when he said something like, we have to be appear before the Lord as a broken vessel. You have to realize that you can’t go forward by yourself. I’m an infant, I can’t feed myself, I can’t change myself, so I lean on Bob Marley a little bit and that’s kinda fractured, you know. I lean on Jimi Hendrix to kinda help me. (Simon often referred to Bob Marley and Jimi Hendrix as idols and ghosts, interests of his father that he never passed down to Simon directly. These figures seemed to offer consolation during the difficult transition into adulthood.) I don’t know. These are all kinda like idols in my life. I don’t know.” Feeling fractured arose from his parents not addressing Simon’s basic needs. Because he could not depend on his parents for these basic necessities, he could not depend on them for further nurturing when he was older. Instead, he turned to the ghosts and idols that filled his parents’ home.

I reflected that it seemed as though he could lean on these ghosts more than his parents, Simon responded, “You begin to make fantasy realms of your reality if it’s not clicking for you. You have to fall off; you have to start using other parts of the universe. You have dig a little, you have to, you know, run off a limb, you know, and to, to keep it from spreading to other
places, you know, you have to be faithful, you know what I’m sayin’, that by sacrificing this limb, you know what I’m sayin’, one day I’ll get it back, you know what I’m sayin’, so I will be complete one day, you know what I’m sayin’. *When times were difficult with his parents, it seemed like giving up a piece of himself seemed preferable to losing himself completely. In other words, losing an arm seems preferable to losing his entire self. Without these fantasy realms, without using these other parts of the universe, the way he was treated by his parents did not make sense. Thus, by sacrificing his own needs for care and nurturance at an early age, he could continue albeit in a fractured state. Furthermore, Simon’s reference to the symbol of the salamander swallowing its tail is meaningful here, as it represents a sense of unity and wholeness.*

*Preparation of the Experiential Constructivist Diagnosis.* I have chosen to provide the description of how we derived the diagnosis in order to illustrate the process of the research group. I have juxtaposed the research group’s decisions with the diagnosis to make the process of experiential constructivist diagnosis understandable to the reader. Throughout the diagnosis, we gave Simon some examples that provided a basis for our decisions about his experiential constructivist diagnosis. However, the research group used many more examples of his struggles than we could provide in a summary. On axis I, we concluded that Simon struggled with self-other permanence and most of the written diagnosis was constructed around this concept. On axis II, we decided that Simon avoided most dependencies altogether. Lastly, on axis III, we focused on discrimination, flexibility, forgiveness, courage, creativity and reverence. We did not describe responsibility, openness and commitment explicitly, as Simon did not discuss these issues directly. In some respects, responsibility, openness and commitment involve being in relationships. Because Simon avoided most dependencies, there may have not been enough material to adequately describe these constructs.

The research team thought Simon struggled primarily on axis I, specifically with self-other permanence. Thus, we began his diagnosis describing his struggles with permanence and the impact of structural arrests:

*The intense struggles you have described in defining who you are may be understood in relation to frequent injuries you experienced at an early age. These injuries affect your struggle to form a solid and stable sense of self—a self that you could use to engage others and the world. For all of us, early understandings of the self are fragile and*
tenuous. However, with reliable and consistent nurturing, these understandings become more solid and stable. Unfortunately, those people closest to you early in life came and went in unpredictable ways, making it difficult for you to develop a stable sense of self. One example of this struggle may be the two ways you describe your mother. On the one hand, your mother was low, depressed and focused on fulfilling the roles she chose for herself. At these times, your mother did not feel very present to you and it may have even felt as though she had disappeared. On the other hand, during her “manic” periods, you describe your mother as vibrant, opinionated and present. At these times she felt most alive and was most your mother. In other words, you felt your mother as very present at certain times, and, at other times, she was gone for you. This is further complicated by the chaos that followed your mother’s manic periods; chaos that often led to institutionalization. Paradoxically, your mother was psychologically present and physically absent.

In this section, we wanted to capture Simon’s fundamental struggle, maintaining awareness of the disparate parts of his self, in a concrete manner. When his mother was “manic,” she would feel alive to Simon. At other times, she would experientially disappear and feel dead to Simon. This psychological disappearance was further complicated by his mother’s physical disappearance when she felt experientially alive. As his parent’s physical and experiential disappearance would often leave Simon alone, he could not develop a solid sense of self-permanence as a young child. Simon’s descriptions of his struggles to maintain a solid and consistent sense of self throughout his life usually involved these fundamental differences in his parent’s values and personalities.

We continued by using an example that Simon provided. He described feeling as though he could see himself from a variety of perspectives but could not integrate these different images of himself:

At an early age, you describe feeling as though you could see yourself from different perspectives, but the inconsistencies you mentioned did not allow for a foundation to build these perspectives upon. For example, you described seeing yourself from different perspectives (Simon my mother’s son, Simon the student), but integrating these roles seemed to be difficult. In order to exist and continue to create ourselves, we need a foundation, a stable sense of sense from which we can experience the world and create a
sense of self that feels correct for us. However, we require help from others and this help comes in form of consistency and attention. Otherwise, as you have experienced, we are left feeling fractured and fragmented, as there is no foundation for these perspectives to be built upon.

We wanted to make the implications of not having a stable and consistent source of attention was important for constructing and maintaining a solid and permanent sense of self. Simon’s description of the ghosts that aided his development also implied that he struggled to feel permanent and stable. His descriptions of feeling less than stable led the diagnosis group to decide that Simon struggled with self-other permanence, as self and other were often experienced as diffuse and fragmentary.

We continued by describing how his struggles with self-other permanence manifested themselves in his present life:

This may affect the struggles you have had in constructing a solid sense of self (by solid sense of self I mean a self that feels permanent, stable and consistent). It is clear you have begun to have a solid sense of who you are, but these understandings are not solid enough. Put differently, you have great success in intellectually beginning to understand yourself, but you still feel confused. You describe setting off on a journey to understand yourself and have wrestled with life’s major questions. Through contemplation and study, you seem to have been able to put words to experiences that remained hidden. Some pieces, however, do not make sense and seem to leave you confused. For instance, the pain that accompanies these inconsistencies in your early development is difficult to intellectually understand. In order to feel solid, our intellectual and emotional understandings of the world should overlap. One could say that you are struggling with creating a sense of self that feels correct for you. A better way to put it may be that you are creatively struggling to create such a self.

In addition to describing how developmental arrests and struggles with permanence manifested in his struggle to maintain a solid sense of self in the present, we wanted to describe Simon’s strengths. To this end, we briefly discussed creativity. The research group hypothesized that Simon creatively struggled with creativity. That is, Simon continuously tried to find creative ways to reinvent himself in relation to others. His reading and study of religion, philosophy, politics and psychology were ways for Simon to understand himself in relation to
others. While he continued to struggle, he derived strength in these studies as well as found ways to maintain a sense of self. Additionally, the diagnosis group saw Simon’s perseverance in this area as a great strength, as the attempt to find a self that feels correct is often a difficult and painful process.

To exemplify his struggle to feel solid and stable, we described Simon’s struggles with self-permanence in relation to integrating his parent’s different views on spirituality:

You discuss trying to integrate two different perspectives of the world. You describe a sense of discontent with the way materialism and traditional religious views get in the way of people living meaningful lives. You also describe learning from Eastern philosophies and religions. You said that it is difficult to let either one go, as they both have equal weight in the universe. This may be true—different perspectives have importance, relevance and validity. It may be good to “cut your losses,” as you discussed, and choose one to base your reality on. Then, you can understand the other perspective and integrate the parts that are relevant. Choosing the aspects of each perspective that feel correct for you, instead of trying to take in an entire perspective, may be something to explore. This may allow you to not only gain a more of a solid sense of self, but also have a sense of growing. There is great strength in understanding that life’s mysteries are just that: mysteries.

In other words, we wanted explain how it was difficult to fully integrate his parents’ differing worldviews. The research group thought that if Simon could choose one perspective as foundational and build upon it with teachings from the other perspective, Simon could feel more stable and whole. For instance, it may be useful for Simon to think of himself as a Christian with progressive political leanings and borrow important concepts from Eastern religions. Conversely, Simon could construct his identity around Eastern philosophy and then integrate important teachings from Christianity. In addition, we thought it would be important for Simon to be able to have a perspective, but also hold in his awareness the potential that his perspective could be invalid. In other words, we thought it would be useful for Simon to realize universal truths would always remain mysterious. For example, Simon described in our research interview that knowing whether a Judeo-Christian god existed was crucial and necessary. Simon had difficulty in accepting that the answer to such a question would remain ambiguous. Lastly, in
line with the notion of transitive diagnosis (Kelly, 1955), we provided Simon with some possibilities.

We connected his struggle to integrate his parents’ perspectives to the distance he felt from his parents. The research group hypothesized that his parents’ inability to provide direct support (instead of the ghosts assisting in his development) arrested his development:

As hard as we try, we can never make sense of all the incompatible views of the universe. An example of this struggle is the way you describe your father. While your musical and philosophical interests are in line with his, he was not able to affect you directly and, instead, you learned important lessons from the ghosts. This had led to a feeling of discomfort as you had “to steal” these lessons instead of him giving them to you. It may be important to realize that you can have these perspectives and have feelings about the way they were given to you.

We hypothesized that this understanding would help Simon develop a differentiated construct of self-other, as he could see that his perspective would be separate from his parents’ understandings of the world.

We moved to axis II of the experiential personal construct diagnostic system. We connected the structural arrests to his ability to trust others:

Due to these struggles with defining yourself in relation to others, it seems difficult for you to depend upon others. Because you were not able to reliably depend upon your parents, it is difficult for you to put yourself in a position to depend on others. Because you have struggled to make sense of them not being reliable enough to depend on, it is difficult to move beyond your parents and explore meaningful relationships with others. Relationships can be awe-inspiring experiences, as others can confirm us in profound ways. At the same time, relationships can be terrifying, as others have the ability to reject and invalidate us as they become closer to us.

We wanted to explain that relationships could be both validating and invalidating as well as highlight the risk involved when engaging others.

We connected Simon’s tendency to avoid relationships with his discrimination struggles on axis III:

Managing this tension seems difficult. All relationships have the potential to injure us. Discriminating between those where that risk of injury is too high versus those where the
risk feels more acceptable can be a struggle. At times, this seems to manifest when you think about sitting down with your parents and talking with them about your past. You are correct in saying that dialoguing with your parents will be an important part of your growth, but it seems as though you have forgiven them before the conversation you want to have with them has ever taken place. This may be dangerous. If your parents are unable to provide the information and answers you are seeking, you may be left feeling hurt again. To put it differently, if the conversations do not meet your expectations, you may end up feeling hurt and invalidated again. Understanding how past injuries have affected your current understandings of others is crucial here.

We described forgiveness in relation to discrimination because it appeared that Simon had difficulty with acknowledging the potential that he could be hurt. Because he had trouble holding a solid sense of self and other, he had difficulty maintaining awareness of the pain from these early arrests. Thus, he found himself forgiving his parents before any of the conversations he desired had taken place.

We then described how courage, creativity and reverence played a role in Simon’s way of being with others:

It is important to remember that people change and your parents are not exactly as they were in the years past. Approaching your parents as though they are as they were when you were young may be setting yourself up for getting hurt. People are constantly changing and re-inventing themselves, and, if we cannot accommodate these changes by letting ourselves change, it is difficult to grow with another person. Alternatively, using these newfound understandings of others and ourselves, we can continue to engage with the people in our lives. This ability to grow in the context of relationships is especially important in our attempts to understand ourselves. It seems difficult for you to experiment with others and the world, if all the different perspectives that you are trying to integrate keep you somewhat confused about your own sense of self. You described feeling as though you are better able to allow others to exist as they are and you described an emerging sense of respect for each person’s position. For example, allowing yourself to take in these positions and be changed by them, without losing your self, may be useful.
We wanted to mention that it took courage to contemplate approaching his parents as he was profoundly injured by them. But, again, we discussed creativity to explain that others are a dynamic process. Lastly, we wanted to describe Simon’s emerging reverence for others and its importance in continuing to grow.

We concluded the experiential constructivist diagnosis by discussing the importance of understanding one’s past in the context of future choices:

While it is crucial to understand your past, it is also important to understand that you choose how you engage the world in the present. There is a tension here. In order to feel free enough to make choices in the present understanding our past is important. But, as you progress through life, your understandings of your past will change. Thus, a final explanation of yourself may always be just out reach.

Because Simon had difficulty sensing that others both change and remain the same, we wanted to stress that self and other is always a mysterious process, one that is never complete or absolute.

While I have provided the entire description of the diagnosis that I presented to Simon, I will provide the unbroken description to facilitate comparison of the two diagnoses for the reader. I provided the following description to Simon:

The intense struggles you have described in defining who you are may be understood in relation to frequent injuries you experienced at an early age. These injuries affect your struggle to form a solid and stable sense of self—a self that you could use to engage others and the world. For all of us, early understandings of the self are fragile and tenuous. However, with reliable and consistent nurturing, these understandings become more solid and stable. Unfortunately, those people closest to you early in life came and went in unpredictable ways, making it difficult for you to develop a stable sense of self.

One example of this struggle may be the two ways you describe your mother. On the one hand, your mother was low, depressed and focused on fulfilling the roles she chose for herself. At these times, your mother did not feel very present to you and it may have even felt as though she had disappeared. On the other hand, during her “manic” periods, you describe your mother as vibrant, opinionated and present. At these times she felt most alive and was most your mother. In other words, you felt your mother as very present at certain times, and, at other times, she was gone for you. This is further complicated by the chaos that followed your mother’s manic periods; chaos that often led
to institutionalization. Paradoxically, your mother was psychologically present and physically absent.

At an early age, you describe feeling as though you could see yourself from different perspectives, but the inconsistencies you mentioned did not allow for a foundation to build these perspectives upon. For example, you described seeing yourself from different perspectives (Simon my mother’s son, Simon the student), but integrating these roles seemed to be difficult. In order to exist and continue to create ourselves, we need a foundation, a stable sense of sense from which we can experience the world and create a sense of self that feels correct for us. However, we require help from others and this help comes in form of consistency and attention. Otherwise, as you have experienced, we are left feeling fractured and fragmented, as there is no foundation for these perspectives to be built upon.

This may affect the struggles you have had in constructing a solid sense of self (by solid sense of self I mean a self that feels permanent, stable and consistent). It is clear you have begun to have a solid sense of who you are, but these understandings are not solid enough. Put differently, you have great success in intellectually beginning to understand yourself, but you still feel confused. You describe setting off on a journey to understand yourself and have wrestled with life’s major questions. Through contemplation and study, you seem to have been able to put words to experiences that remained hidden. Some pieces, however, do not make sense and seem to leave you confused. For instance, the pain that accompanies these inconsistencies in your early development is difficult to intellectually understand. In order to feel solid, our intellectual and emotional understandings of the world should overlap. One could say that you are struggling with creating a sense of self that feels correct for you. A better way to put it may be that you are creatively struggling to create such a self.

You discuss trying to integrate two different perspectives of the world. You describe a sense of discontent with the way materialism and traditional religious views get in the way of people living meaningful lives. You also describe learning from Eastern philosophies and religions. You said that it is difficult to let either one go, as they both have equal weight in the universe. This may be true—different perspectives have importance, relevance and validity. It may be good to “cut your losses,” as you discussed,
and choose one to base your reality on. Then, you can understand the other perspective and integrate the parts that are relevant. Choosing the aspects of each perspective that feel correct for you, instead of trying to take in an entire perspective, may be something to explore. This may allow you to not only gain a more of a solid sense of self, but also have a sense of growing. There is great strength in understanding that life’s mysteries are just that: mysteries.

As hard as we try, we can never make sense of all the incompatible views of the universe. An example of this struggle is the way you describe your father. While your musical and philosophical interests are in line with his, he was not able to affect you directly and, instead, you learned important lessons from the ghosts. This had lead to a feeling of discomfort as you had “to steal” these lessons instead of him giving them to you. It may be important to realize that you can have these perspectives and have feelings about the way they were given to you.

Due to these struggles with defining yourself in relation to others, it seems difficult for you to depend upon others. Because you were not able to reliably depend upon your parents, it is difficult for you to put yourself in a position to depend on others. Because you have struggled to make sense of them not being reliable enough to depend on, it is difficult to move beyond your parents and explore meaningful relationships with others. Relationships can be awe-inspiring experiences, as others can confirm us in profound ways. At the same time, relationships can be terrifying, as others have the ability to reject and invalidate us as they become closer to us.

Managing this tension seems difficult. All relationships have the potential to injure us. Discriminating between those where that risk of injury is too high versus those where the risk feels more acceptable can be a struggle. At times, this seems to manifest when you think about sitting down with your parents and talking with them about your past. You are correct in saying that dialoguing with your parents will be an important part of your growth, but it seems as though you have forgiven them before the conversation you want to have with them has ever taken place. This may be dangerous. If your parents are unable to provide the information and answers you are seeking, you may be left feeling hurt again. To put it differently, if the conversations do not meet your
expectations, you may end up feeling hurt and invalidated again. Understanding how past injuries have affected your current understandings of others is crucial here.

It is important to remember that people change and your parents are not exactly as they were in the years past. Approaching your parents as though they are as they were when you were young may be setting yourself up for getting hurt. People are constantly changing and re-inventing themselves, and, if we cannot accommodate these changes by letting ourselves change, it is difficult to grow with another person. Alternatively, using these newfound understandings of others and ourselves, we can continue to engage with the people in our lives. This ability to grow in the context of relationships is especially important in our attempts to understand ourselves. It seems difficult for you to experiment with others and the world, if all the different perspectives that you are trying to integrate keep you somewhat confused about your own sense of self. You described feeling as though you are better able to allow others to exist as they are and you described an emerging sense of respect for each person’s position. For example, allowing yourself to take in these positions and be changed by them, without losing your self, may be useful.

While it is crucial to understand your past, it is also important to understand that you choose how you engage the world in the present. There is a tension here. In order to feel free enough to make choices in the present understanding our past is important. But, as you progress through life, your understandings of your past will change. Thus, a final explanation of yourself may always be just out reach.

Validation of the DSM Diagnosis. Simon was diagnosed with schizophrenia, paranoid type. While he also was diagnosed with cannabis abuse, we used the primary diagnosis in all cases, as it was the focus of their treatment and was often how hospital personnel approached clients. In writing the DSM description, we used as much of the language of the DSM as possible. We did shorten the narrative somewhat and revised some language that would be unclear to Simon. I will describe how Simon met criteria for schizophrenia and provide the description I presented to Simon.

Criterion A of the schizophrenia diagnosis is the presence of at least two characteristic symptoms (delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms) for a significant portion of time during a 1-month period or less if
successfully treated. Only one characteristic symptom is necessary if the hallucinations are bizarre or the hallucinations involve voices that provide a running commentary on the person’s thoughts or behaviors or if the person experiences two voices conversing with one another. From our discussion, one could consider the ghosts that Simon discussed to be hallucinations. In a later interview, Simon also described having hallucinations that depicted homosexual sexual activity. His interest spirituality and politics was seen as a preoccupation and according to his chart were considered delusional. (His desire for talk therapy, specifically psychoanalytic therapy, as a method of treatment was also a delusion according to the chart.)

Criterion B of the schizophrenia diagnosis is social or occupational dysfunction. These include not engaging in work, school, interpersonal relationships and self-care. Simon fit all three categories, as he did not continue with school and was homeless for a significant portion time before his commitment.

Criterion C is the presence of these symptoms continuously for six months. Simon seemed to have struggled with his symptoms for at least ten years. Criteria D, E and F include a schizoaffective and mood disorder exclusion, a substance abuse exclusion and a pervasive developmental disorder exclusion. Simon did not appear to meet criteria for a mood disorder. He also described periods of abstinence from substances and, in a later interview, described that his symptoms became worse during his last period of abstinence.

One must meet two criteria for the inclusion of the paranoid type signifier. First, one must exhibit a preoccupation with one or more delusions or frequent auditory hallucinations. Second, disorganized speech, disorganized or catatonic behavior and flat or inappropriate affect must not be predominant in the person’s presentation. It is unclear from our interview whether Simon met the first criteria. However, his chart indicated that hallucinations and delusions were very apparent upon intake. During our conversations, Simon did not exhibit exceptionally disorganized or inappropriate speech or behavior.

I presented the following description of schizophrenia, paranoid type, to Simon:

Persons that have struggles similar to yours may be characterized in the following fashion. The essential feature of these struggles is a mixture of symptoms that have been present for a significant portion of time during a one-month period with some signs of the disorder persisting for at least 6 months. These symptoms are associated with marked social or occupational dysfunction.
The characteristic symptoms of such struggles involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, capacity for experiencing pleasure, motivation and drive, choice and attention. Symptoms may be conceptualized as falling into two broad categories: positive and negative. The positive symptoms appear to reflect an excess or distortion of normal functions and include distortion in thought content (delusions), perception (hallucinations), language and thought process (disorganized speech), and self-monitoring of behavior (grossly disorganized or catatonic behavior). These positive symptoms may comprise two distinct dimensions, which may in turn be related to different underlying neural mechanisms and clinical correlates. The first dimension includes delusions and hallucinations, whereas the second dimension includes disorganized speech and behavior. Negative symptoms include restrictions in the range and intensity of emotional expression, in the fluency and productivity of thought and speech, and in the initiation of goal-directed behavior.

Delusions are erroneous beliefs that usually involve a misinterpretation of perception or experiences. Delusions may have persecutory, referential, somatic, religious or grandiose themes. The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear contradictory evidence regarding its accuracy or truth. Although bizarre delusions are considered to be especially characteristic of such struggles, “bizarreness” may be difficult to judge, especially across different cultures. Delusions are deemed bizarre if they are clearly implausible and not understandable to others and do not derive from ordinary life experiences.

Hallucinations may be auditory, visual, olfactory, gustatory and tactile, but auditory hallucinations are by far the most common. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person’s own thoughts. Hallucinations may be a normal part of religious experience in certain cultural contexts.

The speech of the individuals with such struggles may be disorganized in a variety of ways. The person may “slip off the track” from one topic to another; answers
to questions may be loosely related or completely unrelated; and, rarely, speech may be so severely disorganized that it is incoherent. The symptom must be severe enough to substantially impair effective communication.

Grossly disorganized behavior may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living such as preparing a meal or maintaining hygiene. The person may appear markedly disheveled, dress in an unusual manner, display clearly inappropriate sexual behavior or display unpredictable and untriggered agitation.

The negative symptoms associated with such struggles include affective flattening, alogia and avolition. Affective flattening is especially common and is characterized by the person’s face appearing immobile and unresponsive, with poor eye contact and reduced body language. Alogia (poverty of speech) is manifested by brief, laconic, empty replies. Avolition is characterized by an inability to initiate and persist in goal-directed activities. The person may sit for long periods of time and show little interest in participating in work or social activities.

Individuals with such struggles tend to have difficulties in major areas of functioning (e.g., interpersonal relations, work or education, or self-care). Typically, functioning is clearly below that which had been achieved before the onset of symptoms. Educational progress is frequently disrupted, and the individual may be unable to finish school. Oftentimes, individuals with such struggles do not marry, and most have relatively limited social contacts.

Such struggles tend to begin in the early to mid 20s for men and the late 20s for women. The onset may abrupt, but most individuals may have social and occupational difficulties before experiencing symptoms. Some individuals may experience periods of relative health, while others remain chronically ill. Complete remission is probably not common in this disorder. Of those who remain ill, some appear to have a relatively stable course, whereas others show a progressive worsening. Treatment is usually more effective for positive symptoms (e.g., hallucinations), but negative symptoms tend to persist and, sometimes, may become steadily more prominent. Some predictors that are associated with a better outcome are good pre-illness adjustment, acute onset, later age at
onset, good insight, being female, associated mood disturbance (e.g., depression), treatment with medication soon after the onset of illness, consistent medication compliance, brief duration of active-phase symptoms, good functioning between episodes, minimal residual functioning, absence of structural brain abnormalities, normal neurological functioning, a family history of mood disturbances and no other family members experiencing similar struggles.

Individuals with such struggles often experience these symptoms in a variety of ways. Some symptoms are more prominent in some individuals than in others. The essential features of struggles similar to yours are the presence of prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning and affect. Disorganized speech, flat emotions, inappropriate expressions of emotions, disorganized behavior is not prominent. Delusions are typically persecutory or grandiose, or both, but delusions with other themes (jealousy, religiosity, or somatization) may also occur. Hallucinations are also typically related to the content of the delusional theme. Associated features include anxiety, anger, aloofness and argumentativeness. The individual may have a superior and patronizing manner and either a stilted, formal quality or extreme intensity in interpersonal interactions. The combination of delusions and anger may lead to violent behavior. Because there may be less neurological and cognitive impairment, prognosis may be better especially in the areas of occupational functioning and capacity for independent living.

Presentation of Experiential Constructivist Diagnosis. Before presenting Simon with his experiential constructivist diagnosis, I asked him about his personal theory of psychological struggles. He replied, “I don't know. I think, like I said, I grew up kinda in the Christian church, so I always looked at it as a way, as the sins of the father kinda falling on the children also. It’s something the parents or the grandparents did, something to anger a deity or something that kinda fell on the kid, you know what I'm sayin’. And, I kinda see that in my life you know ‘cause I had a great grandmother that was in this facility back in the 70’s before I was born, and my mother struggles and I have an aunt on my father’s side who also struggles. But, I don't know, that’s kinda mean—I don't think it’s no concrete thing, you know what I'm sayin’, like I think a lot of people are kinda artistic or enjoy the arts it seems like a lot of them struggle also with psychological problems also.”
“What do you think the role of doctors, therapists and psychiatrists should be in your treatment?” I asked.

“I was kinda angry when I first got sent down here but I'm glad a place like this exists but I'm still real skeptical about the success rates in using the psychotropic medications, you know. It doesn’t help me at all, you know, and I've been here over two years and I've recognized my tendency to be violent, and I've recognized—and I've come to some conclusions as to why I've been violent like this, exceedingly violent over the last few years, but I just think the way that the mental health institutions are going is going to be more damaging, you know. ‘Cause they are going more with medication and less with talk therapy, you know. I think that it is more important to talk your way out of your sickness rather than to drug your sickness…I don’t see, you know, it’s like, it’s like $400 for a person a day here, you know, and I figure, I figure that money could be better spent. ‘Cause I can’t see it, you know, I do see a couple of doctors around here—the pursuit of wealth is something that kinda interests me also, you know so, I don't know I've been trying to look at social systems where wealth is spread out a little bit more even,” Simon explained.

At this point, I invited Simon to read the experiential constructivist diagnosis. Unfortunately, a few minutes of conversation that concerned his initial impression were not captured on tape because of technical difficulties. He mainly described the ways the diagnosis captured his relationship with his mother. He also resonated with the idea that his sense of self mirrors his parent’s differing perspectives on the world. I asked him how it captured his strengths and weaknesses.

“I think it did a pretty good job. I think it was really insightful about my father and how I was influenced by him, probably in the early 80s, but, as I got older, it kind of left and maybe it was his purpose to try to cram all of life’s lessons in a very short period of time and it didn’t leave me the opportunity to develop a lot of insight I would need to deal with other human beings, you know. So, I felt like you kinda hinted through here, you know, that maybe, maybe all of life’s lessons that I was to learn from a man to become a man was crammed into my baby years, my infant years, my early, early years you know, you know what I'm sayin’. He kinda just sat back and allowed me to fumble my way through the fog you know, instead of being there, you know what I'm sayin’, that could be, I mean that could also be a reality from his childhood,
you know what I'm sayin'. Maybe he didn’t have the opportunity to have a male role model in his developing years of life to help him deal with life’s questions.

I reflected, “So kind of, you got a whole lot of stuff in this short period of time really early on and the rest—”

“Yeah, like a cram session or something. Crammed it all in, you might get a few points of ‘Ahhhh,’ but the bright lights and flashes kinda appear too. But, the real lessons, that are woven into the fabric of everybody’s existence, I kinda didn’t get too much of those. I got the beautiful things. I got the arts, you know, but I didn’t get the hard lessons. This is a cruel world, you know, those things didn’t echo real hard while I was developing. I didn’t really have those things, so I was kind of naïve when I went in to the world and I feel like it cost me a lot.”

“The big picture sorts of things?” I responded.

“Yeah. Maybe trust, and who you could depend on.”

His statement about trusting others reminded me of what he had said earlier (in the unrecorded section). “I wanted to go back to when you said it was pretty good about capturing your mom’s ups and downs. How do you think it captured the effects it had on you and your own sense of self, sort of not giving you the foundation you need as a young kid to have all that?”

“Well, it’s kinda the same way, you know what I'm sayin’, like I kinda enjoyed the artistic areas, you know what I'm sayin’, where she was really creative and the such, as opposed to when she was depressed. So, maybe it was the same thing with my mother you know, and you saying how she was psychologically present, but kind of physically absent. So it was pretty good, you know. She took care of the mind and things like that but not like physical aspects.”

“So is it the part about her not being around, that part, is that what you mean by physical aspects?”

“Nah, well just, like who you can trust. I mean we went to church every Sunday…so she was concerned about my position in the next life you know, but not so much this life. So, on both sides, I was left on my own to do what I wanted to do when it came to this life in relationship to these teachings that kinda carry into the next life. But, no real solid foundation to build upon when it came to this life you know, at least the uh maternal side of it you know, like caring, I didn’t get a lot of that.”

“Is there anything that it doesn’t capture about you, things that are missing?”
“Uh, pretty much, pretty good, you know, from what I can remember, it talked about my dad and my mom the physical and having to kinda steal for attention, difficult to depend on others. I think I was naïve to the point where I could depend on characters that really didn’t have very much morality about them. I think I was allowed to develop my own view of the world to the point where it destroyed me, because I found I was able to find trust in people that—well, I guess I’m not destroyed, I guess no one is ever completely annihilated—but I’ve had to learn some lessons that are pretty difficult. I’m still doing it now when it comes to trusting people ‘cause I kinda, and I guess it’s kinda good to kinda look at the world as a wide eyed child you know, to be childlike. I guess that’s good, you know what I’m sayin’, to be like that ‘cause you tend to be able to bounce back from disappointing relationships, let downs you know, so I guess it wasn’t too bad that it allowed me to be kinda a child…But, I’ve had to learn some lessons that I feel like I wouldn’t have had to learn if there would have been more men in my life you know, instead just letting me go.”

“Sounds like it’s hard to figure out who to trust and that’s lead to some huge disappointments for you.”

“Yeah, I got into some relationships that were quite hurtful.”

“There were certain things you needed to know.”

“I mean if I would have got it at home I wouldn’t have been out in the world to find it, you know what I’m sayin’, where that trust could be abused you know. If I would have learned it at home I wouldn’t have been susceptible to some of society’s ills. I think I would have missed this place by a few miles. I think I would have made it more into the next realm, next reality, next relationship, next thing with a little bit more success, with less pain.”

“You talk a lot about the pain—”

“Yeah I think life would have been a little bit more detailed. I just didn’t miss the hard stuff, but, I guess that’s what makes life life, the ups and downs you know. But, gosh, I’m only 33 you know, and this has been three years of my life [three years in this facility], you know. That’s one-tenth, that’s a lot of time, I believe, to be dealing with something I should have learned, you know, 5, 6, 7 years old, you know. I think all things happen to you, you’re always tempted to go down a different path in your life and I think if I would have had a little bit more structure as a youth, as an adolescent, then this necessary evil probably would make the world what it is. I wouldn’t have missed it you know. I guess, I value time, I value its wonder, its
mysteries, it’s—it’s not a very concrete. Look at time. It’s kinda like Einstein’s, it’s kind of elastic. You look at time you know, time expands and contracts, you know, and it just seems like I spent so much time in this area, that I wouldn’t have had to, but, I guess that’s what makes me me you know. I wouldn’t be at this day today, you know. I wouldn’t be this moment, so I'm happy that I'm in this moment still, regardless. But, I’m thankful at my parent’s kind of keeping me childlike. I'm not over it yet, but I'm still kind of bitter, but I'm thinking I’ll get over it eventually.”

He valued the pain as it gave him strength, but also stunted his growth. Thus, I replied, “the way you are talking, it seems like you really put yourself on the path to do that, that’s the sense I've gotten from talking with you. I don’t know if we talked about it explicitly or not but—it seems like you have put yourself on the path to figure that out, you said ‘I haven’t completely figured it out yet but I'm—’”

“I'm still—it’s a reality that’s threatening my relationship with time ‘cause it’s constantly trying to put me in situations where I would have less control over my actions, my comings and goings. It’s constantly threatening my position and its depress—I wouldn’t say depressing, but it’s hard to deal with you know, ‘cause I feel like I should have missed it. It shouldn’t have got me you know, but—” It appeared that Simon knew that the pain and injuries in his life made him idiosyncratic and unique, but also caused him pain and troubles.

“So how does this understanding of yourself make you think about change?” I asked. He misunderstood my questioned so I rephrased it, using a hypothetical therapist. “If you were working with like a therapist that had this understanding of you, how would you see personal change? Is it possible? Is it hard for you to do?”

“I don’t think any thing is impossible, I've always, I've always kinda been optimistic, and that’s something I got from my parents. But, I value anybody. Be they a doctor, be they a therapist, be they a patient, be they a bum on the street, that would take time, that will sit down, whether they are being paid or not and say, ‘Hey, what's going on in your world?’ That is the one binding reality we have as human beings. We have to communicate, you know what I'm sayin’, one way or another. And, I look at each opportunity to discuss myself or to listen to someone talk about them self, as a way to better myself. So, even if this is a dark destructive place to be in, I'm always looking for that next bit of light that’s coming from somebody else, that I can kinda gravitate to, to get warm and to get—to displace the darkness. ‘Cause I do, I
think this is a dark world. Kinda like the Gnostics think. It’s a terrible place to be, but you gotta keep your optimism and say, ‘Well I'm going to get up today and I'm going to find that relationship that’s going to define me. And, I'm going to get on my little hover craft and go to the next place, and when my hover craft breaks down, I’ll put my boots on and start walking to the next planet. I'm here for a reason, I'm here for a purpose and I gotta keep moving you know. And a lot of things are threatening me—keeping it moving, and I loath that, I don’t like that at all, you know. I had, I had such a big stride, you know, and maybe that’s it. I had such a wide stride, trying to cover ground, that it hurts. It’s playing its self out physically too. My knees are going bad ‘cause I'm not walking like I used to. I'm not covering as much physical ground as I used to and it’s wearing down on my body.”

I was interested in the connection between his difficulty trusting others and the notion that relationships and discussions with others serve as a light, a source of hope, in a dark world. “I'm getting the sense that even though it’s a dark place to be there always someone willing to get into it with you and talk about what's going on inside, it gives you hope.”

“Yeah, I believe that sometimes it really is a cruel, dark, cold world, but I believe it’s human beings, there’s always that opportunity that you are going to spark it. You’re gonna fall in love, romance will be in the air, something you know, it’s always—”

“Do you feel like this opens up some possibilities for you to be thinking about?”

“Yeah, I mean, I haven’t really talked a lot about—I’ve never talked to anyone about my mother, you know. So, just opening up that can of worms, I feel like it’s going to be hard to close the can from here on out. I mean she is singly the most influential person, I think she influenced me more than my father did, and having that can of worms open is something that I'm going to have to carry into my next relationships. So, I'm going to have to look at my mom and look at myself before I can go out and try to find someone to talk to you know. I'm going to have to take this in to my circle also. I think that’s a positive thing…It may take some trial and error to get proficient at it you know, [laughs sardonically] ‘cause she’s a character you know, she’s a character. But, I definitely think she’s someone that I want my friends, my loved ones to know. I want her to shine through me, and I want people to see that, yeah, she too was a beautiful person in this dark world.”

“Is there anything that is helpful in terms of what you are saying, negotiating relationships and trusting others?”
“I don't know. It has been pretty helpful to talk about it and to be able to attack it from another angle you know, because it gets—you have this weight on your back, that you’re carrying, all us human beings have it. And to be able to shift the weight a little bit, ‘cause right now I'm emotionally screaming out, I'm being crushed under the weight of my, of my little life package. My brain is screaming out by the path of schizophrenia. I'm hearing voices from things that are not there, it’s the pack I believe, it’s weighing me down. And my spirit and my body is saying, ‘Whoa, this is too much for us, we need to adjust so we can continue on or we’ll perish.’ Hopefully, I’ll be able to shift my weight a little bit, shift the weight of the package on me a little bit so I can move a little bit faster each day.” The weight of this package became a powerful image in our conversations. Trusting others and shifting the weight, were crucially connected, as we shall see.

I asked what he would think of a therapist using the experiential constructivist conceptualization and Simon answered, “If the therapist came back with this I would, uh, I don't know, I probably would value a little, I would value what he had to say if we met again you know, cause I've had therapists that, you know what I'm sayin’, they are so hell bent on the pharmaceutical side of therapy that you don’t have the opportunity to kind of pick apart this life. So, I would be encouraged…and would be interested to continue to see if I could be healed through these meetings—that I could move on. I have to look at things from a historical standpoint, you know. For the most part, my contact with the mental health field institution has always been darkened by someone’s desire to medicate the problem, you know what I'm sayin’. So, I would be, like I said, I would be interested in continuing to pursue things along this path.”

He paused for a moment and continued, “It’s kind of like Aristotle you know, where you have a great teacher you know what I'm sayin’, and I guess, I can’t pronounce the name of the school or the group of people that follow him. But, while he would be speaking about life’s lessons and values and morality, all these subjects that he touched upon, they’d be walking with him. And the name of the group of people that walked with him, it actually means to walk with me. You see a psychiatrist for ten minutes, and you leave the office with a needle in your butt or a new prescription of pills, and you’re kicked back into the cold world with these magical little pills, instead of walking together, taking time to unwind, to live and trust. I always was hoping that a charismatic leader would show up you know what I'm sayin, that would kinda take life
from what Aristotle did, and I'm sure they are out there. I know they are out there ‘cause I've come in contact with them.”

I replied, “So in a way its like you would want to go walking with your therapist and talking to figure stuff out.” Simon responded, “Yeah…I mean walking in this dark world by yourself you realize, yes, you too are dark. You are a dark, twisted, neurotic, sick person and to walk with someone or to have contact with someone that doesn’t have that, you know what I'm sayin’, it inspires you to want to kind of pass off this reality that we have as human beings you know.”

“Pass off?” I replied, as I did not know what this meant.

“Pass off, I mean we all come from the Earth, you know what I'm sayin’. The Earth is a destructive—I mean it’s a dark gloomy place. It can be, you know what I'm sayin’. And, you take on those characteristics as you’re searching for yourself and to find someone who is less, or appears to be, or can put on the façade that they are not as dark as you are, you know what I'm sayin’, that’s always attractive you know what I'm sayin’. So, you want to peel back the layers of yourself, so you can see yourself as one that has been successful in shunning the dark aspects of the Earth you know, you become more successful I believe—hopefully, hopefully.”

There was a lot I wanted to explore in Simon’s response. It seemed as though he meant both therapist and client are borne out of the same material; through living on this earth, both would have experienced the darker aspects of existence. Both being aware of these darker aspects of their lives seemed important and I wanted to explore this with Simon. It also lead me to think that Simon knew the negative impact power imbalances could have in therapy, while simultaneously acknowledging that the has figured something out to live meaningfully or can at least put on some façade of mental health. I was reminded here of Rogers’ (1957) conditions for therapeutic change in that the therapist is more congruent than the client. I offered my understanding to him and Simon began to use the metaphor of the therapist using the body to help him move or taking the heavy package he carries around throughout his existence.

I asked him if he felt that he would be equal with this hypothetical therapist. Simon hesitated and said, “Equal? I wouldn’t feel as alone, you know, ‘cause my path, my path has led me down some pretty dark back roads. I would feel like somewhere, somewhere in our discussion there would be a map or a light that would lead me back to the main strip of highway.
If I was dealing with this therapist, you know what I'm sayin’, I would feel safe. I would feel, I guess, equal in a way. So, yeah...we could create something, you know what I'm sayin’.”

As I heard Simon’s words and the reappearence of trust in our dialogue, I assumed he could trust this therapist and told him so. It seemed difficult for him to answer directly and he began, “I don't know—trust is a loaded button. I think, I think you expose yourself when you, and I guess this is, I mean I think this is all, everything is ordered in this society, in the world that we live in every thing is ordered you know, so you know what I'm sayin’, I believe, I believe the more practice you get at meeting somebody head on the better you get at it. So, there is a lot of time, a lot of your momentum is continuously being used, so you kind of press each other and you kind of put pressure on each other to bring out the best in both of you. So, in my case, I, I like I said, I've done a lot, I've covered a lot of ground in my life and so I believe that I have the ability to kind of hit, hit [things] head on, and that momentum it kinda is mutual, or it is something that can be felt on both halves I believe.”

In listening to his words, I was struck by the accuracy of his statements. The therapy relationship is not a unidirectional process where therapist helps client change. I could not have thought of a better way to say that both client and therapist reinvent themselves in the relationship. Both put pressure on one another to bring out the best in each other. I thought of my experiences as a young therapist and the ways I have felt pressure to bring out the best in myself in my interactions with clients. Simon also brought up the idea that he had something to offer a therapist who was willing to listen. He had made a lot of progress in his life and had learned things, even though he had taken the longer path, as he described it. I could also hear the longing in his voice to have such a relationship.

Simon continued, “I already have a little inside information. You have set yourself up to kinda be vulnerable, you have to give, you know what I'm sayin’, to be able to have that title on the door out there on the wall, psychologist or psychiatrist. You have to kinda open yourself up to ridicule too—the direction in coming back that is an opportune situation. Because I'm coming hard and your coming with a perspective, with a title, with a modus operandi that is beneficial to the way I'm coming. I'm not coming to destroy with my directness but I'm coming to say, ‘Hey this is me. I'm going to be here for a minute. I'm a lover, I'm a romanticist, I'm an artist, what can I get so when I move on maybe I’ll see you somewhere else as this journey unfolds.’”
It also seemed that Simon knew that if a therapist was not fully present, the therapist also would remain a ghost in his life. His words from our second intake interview echoed back to me. In describing his view of paradise, he described that the ghosts who influenced him would disappear: “maybe I will be able to interact with them in a different way... There will be no more ghosts ’cause everyone will be in flesh, these lessons, these people that I meet here, they won’t be incomplete, you know what I’m sayin’, they won’t be an abstract painting anymore, you know what I’m sayin’. I’ll be looking at it complete—it won’t be fragmented anymore.” The need for someone to be present, to enter his life in a way that was not fragmented seemed crucial here. Furthermore, I began to wonder about how the diagnosis elicited these discussions of trust. It was very interesting that the issues that would arise in the experiential constructivist therapy, issues related to his ability to trust this therapist, began to unfold as he further processed this diagnosis.

The word “vulnerable” stood out to me and I started to wonder he meant. I had a lot of ideas about what therapists needed “to give” and what they needed to be vulnerable about to relate to an other. “What do you mean by vulnerable?” I asked.

Simon responded, “I think, I think for someone to make a career out of listening to people I think you would have to be knowledgeable in some of the more, uh, you have to have...a death wish or a curiosity of the unknown, you know what I’m sayin’. Every day you like to play the devil’s advocate with the dark earth. You would be interested in taking chances and playing with fire, I guess, you know.”

“Because you are listening to some pretty painful stuff?” I asked.

“You have to stay motivated. But that’s everybody too you know, but especially for psychiatrists and psychologists, I mean this is your job, you know. I’m out on the street—I do meet people, you know what I'm sayin’, and they have the same baggage, they have the same connection with the earth, you know, and, so, it too, you know what I'm sayin’, but I think here you’re a little more likely to run in to some of the more gritty feeling, more dark feelings. People are more apt to open up to you than to open up to me on the streets you know. On the streets there be a lot of superficial small talk “How’s the weather?” “Who won the game?” you know, and that’s what I want to get to eventually, you know what I'm sayin’. ‘Cause I think the art of small talk is a skill and it says something about the person that can do it also, it’s
something that I haven’t quite got you know, but I keep moving, you know what I'm sayin’, and hopefully I’ll be able to press when this journey is over you know.”

Simon paused for a few moments. “I hope I didn’t discourage you or anything.” I told him he had not and it actually was validating to hear him say this to me. Simon seemed relieved and said, “You gotta be, you gotta kinda get a kick out of laying on that couch, you know what I'm sayin’, and letting somebody pick you apart, you know what I'm sayin’, you have to kinda be, I don't know if its sadistic or masochistic…but you kinda have to get a kick out of pain, you know what I'm sayin,’ you kinda have to get a kick out of pain.” Intrigued, but trying to keep my role as researcher at the forefront, I asked him the next question on my list.

“Does this diagnosis make you feel victimized at all?”

Simon replied, “I don't know. I wouldn’t say victimized. Kind of like I could leave my package here for a minute and, hopefully, hopefully, I can move on with a renewed sense of purpose. I think somewhere in my life, and somewhere in all people that seek to understand who they are, you kinda wake up one day and say, ‘Well I'm going to be victimized today. Someway, somehow I'm going to be victimized.’ And, you have to incorporate that into your life, you know what I'm sayin’, and say, ‘Yeah I'm going to be victimized today.’ Where is it going to be and how dark is it going to be, how painful is it going to be, how long am I going to be in that situation, you know? I mean you have to embrace that to overcome the negativity, you know what I'm sayin’. Obstacles are going to come, you know what I'm sayin’, and you’re not superman. Something is going to get you and you have to kind of wake up knowing that that is going to be a part of your day, you know what I'm sayin’. So, it’s something that you have to embrace or at least be able to shoulder against it in your life. And, I think most people kinda come to that, or I hope most people kinda come to that, ‘cause I think that’s one of the universal truths, universal realities, you know what I'm sayin’, that will cause you to be unsuccessful if you get up thinking, you know, everyday, that nothing is going to hurt you…I think eventually you will be let down and you have to start over again. ‘Oh, I'm going to be victimized today.’ But it’s all progressive. It’s a roller coaster ride. It’s got its peaks and it’s got its depths, its valleys.” I had difficulty interpreting Simon’s answer to my question. He seemed to say that if one accepted suffering, it would be difficult to feel victimized. Put differently, he seemed to believe that a meaningful life necessitated embracing suffering rather than avoiding it. Victimized meant choosing to not accept this darkness and pain, which was also a choice to continuously
“be let down.” Furthermore, life included both pain and happiness or peaks and valleys. The therapy relationship, however, was a place to relieve this suffering by allowing someone else to hold his experience for a moment.

After we broke for dinner, we began to discuss how this hypothetical therapist would see his ability to change. “It kinda says maybe that I changed too soon, you know what I’m sayin’. It kinda sounds like it’s saying that I’ve already went on without them, I’ve already kinda made new idols out of the old idols and I’m hanging out with the new idols before I resolve issues with the old ones.”

I attempted to clarify the section of the experiential constructivist diagnosis that referred to the conversations he imagined with his parents. I explained that his parents might not able to provide him with the information he sought. Simon replied, “I guess your kinda saying that maybe I'm holding something against my parents, but in the conversation that we’ve had, I've already forgiven them before we’ve even embarked on opening up these types of conversations.” I explained that forgiveness is difficult. While forgiving those who have hurt us in the past is important for healing, forgiving others too quickly leads us to getting hurt again. My investment in the experiential constructivist diagnostic system may have affected my reply to Simon.

Simon replied, “Yeah, only they’ll recognize a lot of themselves in me and they won’t want to injure themselves, you know what I’m sayin’. So, they’ll be, I don't know though, I don't know, I was thinking that they might be able to—we might be able to walk into the sunset together but I don't know. My dad, my dad might wanna chop his own limbs off before he owns up to his things, you know. I don't know, hopefully they say, ‘Oh yes, we helped develop this young dude, so…we’ll help put him on the right path.’ My dad’s a pretty hardheaded being, he’s just like that he’s very bull headed.” For Simon, healing often was discussed in absolute terms. For example, everything needed to be understood and put in its proper place, an impossible goal. His response reflected this tendency in his thought. But, his realization that his father may not live up to Simon’s expectations may be due to the diagnosis and our conversation.

“I guess the question becomes what happens if they can’t give you the information that you want. How do you feel about that?” I asked, hoping to understand Simon’s fantasies of these conversations in more depth. He replied, “They—I would probably just watch them die a slow death. I don't know.” His response indicated that Simon could empathize with his parents, but there was a lot of pain that was associated with empathy. Simon saw his parents as living a life
filled with emptiness due to the inability or unwillingness to examine their lives. In many respects, Simon was aware of the traumas in his parents’ pasts and understood that these traumas affected their ability to relate to him. However, Simon’s empathy with his parents did not erase the pain Simon felt in his relationship with them.

I wondered aloud if he could move on after the death of his parents without these conversations taking place. Simon responded, “I think because I recognize so much of them in me I’d probably allow, like Jesus when somebody does you wrong you forgive them seven times 70 or something like that, when it comes to my parents. But I might really have to draw a line there too. I’m getting too old to be having these kinds of conversations with my parents. Emotionally they’re, I don’t know if you’d call 50s the twilight of life, but they’re getting pretty old. I think these issues have to be resolved soon before history repeats itself, ‘cause I got nephews and nieces that are coming up now and if my issues don’t get resolved then I’m sure the next generation’s health, spiritual well-being, will be jeopardized, you know. So, I have to get off my hands and really push them, but it’s scary, ‘cause I know how my dad is. I remember asking him some questions when I was a kid—he just blew like a volcano. I hate to be on the receiving end of one of his tantrums, you know. But I gotta know who I am so I can move on ‘cause I feel like this whole mental illness thing, it’s some behavioral coping mechanism I developed to get some type of nurturing, you know what I'm sayin’. I feel like something was lacking you know. And, they’re probably saying, ‘Nah we did this and we did this—we did everything for you. Look at what we did.’ I think they took care of me physically but their two ideologies of how to raise a family were kinda bumping heads. My dad was off into the more like Afrocentric, you know, this kind of political music. My mom was a Christian-type, you know what I'm sayin’. But, they both came from backgrounds where there was heavy drinking, there was a lot of drinking, and out of wedlock children. I gotta get the questions answered. ‘Cause I feel like I’m not even existing until I get these issues resolved, you know. I feel like I’m just the primordial elements before the development of the universe, you know what I’m sayin. Those basic elements that allow for the whole universe to develop, I'm kinda that muck, kind of just unformed clay. I'm not even here. I'm just nucleases and atoms, protons and electrons, that are not really formed yet, you know, because of these questions you know.”

I asked if the hypothetical therapist would see him as able to mold himself in this way. “I think we could go into training like an athlete you know what I'm sayin’. We can do wind
sprints together, we can do calisthenics, but you can’t run the race for me you know what I'm sayin’, you can just kind of coach me to get to that starting point and prepare me up to that point, but I have to say ‘Mom, dad.’ I have to take off you know what I'm sayin’, when the gun goes off you know.” For Simon, therapy was similar to athlete’s training in that he needed to become stronger. It appeared as though therapy would be a place for him to develop a sense of courage to have these important conversations for his parents. He continued, “I don’t want to stay practicing my whole life you know, I wanna get on the winner’s stand or go home defeated you know.” There was also a sense of urgency in his desire to ask his parents questions about the past. As he mentioned previously, as his parents grew older they would literally die and he would lose the opportunity to have such conversations. On a symbolic level, if conversations regarding his past and upbringing did not take place, Simon would also become a ghost.

I asked if he could trust the therapist, as his use of the words training and coach denoted a relationship I did not completely understand. He responded, “I feel like I’ve had enough of these practice sessions with my parents to get to the point where its not so much that I have to trust the therapist, I feel like the therapist has already exposed himself to be kind of like a surrogate, a step in, you know what I'm sayin’. I guess I have to trust myself to recognize that I don’t want to be in this dark place.” For Simon, once the therapist was willing to enter into a relationship that rivaled his relationship to his parents in terms of its level of intimacy, he would need to take the responsibility to actually run the race. He continued, “When you decide something in the universe that you want to make a change, I feel like the universe starts to put those things in motion for you, and you have to stay true to yourself if you want to be able to be embraced by this part of the universe that opens up too.” I wondered if he thought the therapist would be the motion he needed and he would have to be responsible and courageous enough to embrace the parts of his universe that were tremendously painful.

I was reminded of the image of being in a hole and a therapist helping him out of the hole. I asked, “Would you trust the hand coming out to help you out, not that this person would do it for you, but would you trust that the hand will be sturdy?” Simon responded, “I think therapy, I think this experimental stand-in for my parents, it’s more me. I would like to fantasize that the therapist is running with me…I feel like it’s a very powerful situation, but very, I mean, you could catch it. If you’re not sincere, you could catch the cold—it could spin you off too.”
I reflected, “This therapist needs to be able to hear these things and sort of be inoculated—kinda have the ability to kind of be there but not catch the cold at the same time.” He responded, “Right. I'm getting toxins out of my system and if the therapist isn’t healthy or if the therapist isn’t up on his own psychosis and how they look at the universe then it can get them too. I mean especially in a young career if you continuously are bombarded with negative—I think if you’re not prepared to do a job like this you shouldn’t do it because it is like—if you don’t have a positive outlook of your own experiences then you could subconsciously pick up some of the one that’s in therapy.” I silently wondered about my own level of preparedness. I noted that it seemed as though the diagnostic conceptualization was less important than the therapist’s ability to hear his words and be present with him.

Simon responded, “Well, it’s like I said its just its an experiment right now. I'm trying to gear myself up to ask my parents these questions, so you’re mostly just a sounding board right now you know, but I'm saying, you know, some of those sounds could get picked up by your own subconscious. You could begin to question your own childhood, your adulthood, where you are at, your political ideology, whatever, you know what I'm sayin’. I think you have to be strong, you have to, I mean it takes years and years to be in a position like this, a lot of study and I guess I've come to the point where I'm comfortable talking to psychologists because I've met—I've had more success in finding a community of people that have read things that I've read. I haven’t found the opportunity to sit down and say, ‘Hey you know, I've read this book.’ And you’ll say, ‘What? You read that book? What?’ I've found well-read psychologists that say, ‘Oh!’ and that makes me more comfortable. So, it loosens me up to say, ‘Ok. I really want to tap into this question with my parents.’ And, I can practice, you know what I'm sayin’, and I can get feedback. I can be encouraged you know what I'm sayin’, to go ahead and tackle the mountain you know, climb to the top of the mountain and see what they doing up there.” Trust, for Simon, meant at least two things. First, Simon needed to be able to trust that the therapist would be able to hear his words and not begin to lose his or her sense of identity. Second, Simon believed that he could trust someone more readily who shared the value of self-understanding through study. Thus, knowing that a therapist has studied life’s questions in relation to their personal lives is important to him and prerequisite for Simon’s trust.

I asked him if the approach offered by the experiential constructivist diagnosis would be helpful for him in this regard. “For me, it’s helpful because this is the first concrete, outside of
just therapy sessions, this is something I can look back to in the future and have something concrete to look at and say ‘Oh, this is how he felt about this.’ And, I can kinda use it to approach my parents in a different way. But, I think it’s helpful for me—I don’t know if it will be helpful for everyone but it’s helpful for me.” *For Simon, the experiential constructivist diagnosis was a useful tool in realizing his goals. While I believe he meant that it would help him literally approach his parents in a different manner, it may also help him approach his understanding of his parents and their relationship in a different manner.*

Continuing on the theme of the utility of the experiential constructivist diagnosis, I asked if someone using this diagnosis would be limited or missing some aspect of his experience. He responded, “I think I would like to know more about my parents, you know what I'm sayin’, ‘cause it would allow me to talk about some of the things I haven’t talked about. Just to see, I mean, I'm looking for someone that’s been down some of the same roads as me. So, when we’re passing these signs you can say, ‘Oh, I passed that sign too and I sped up a little bit or I slowed down or I pulled to the side of the road for a minute.’ And, I can say, ‘Well, I got out and walked. I tried to cut the sign down.’ And that’s just important for me, I feel like I’ve traveled so far off the main path, you know what I'm sayin’, that all my friends and my peers took. I feel like I’m sitting alone, you know what I'm sayin’, so it would be helpful for me. ‘Hey, have you ever done this, have you ever done that.’ I think that would help me.” *As mentioned previously, Simon prioritizes the person of the therapist over the conceptualization. While the approach offered by the diagnosis would be helpful to him, he would like to know more about the therapist and his or her life journey. Simon valued the examined life and he could trust a therapist who shares this value. Furthermore, if the therapist knew the terrain, he or she could not discount his experience and his words as signs of mental illness. This prerequisite for trust is not surprising considering Simon’s trouble trusting others, especially mental health professionals. As will become clearer in the next section, the experiential constructivist diagnosis represented this value of the examined life and thus he would find it a useful and meaningful conceptualization.*

*Presentation of DSM Diagnosis.* Simon spent a good amount of time with the DSM diagnosis, reading, underlining and making notes to himself. When I asked for his initial reactions to the DSM diagnosis, he lamented that he did not make as many notes while reading the experiential constructivist diagnosis. He offered his initial reaction however: “This one is
kinda a little bit more, clinical, I guess, but I can't really say that the other one, I don't know, the other one seems to be more—I don’t know.”

“What do you mean by clinical,” I asked.

“Uh, like you would read in the DSM-IV [points to the DSM on the shelf] or something like that. A little bit more—medical, medical. The other one seems, and I think they are both necessary, you know what I'm sayin’, but I don't know, I can say that one [EPCP diagnosis] it kinda seemed a little bit more, I don't know [long pause]...I don’t know ‘cause they are both pretty good, but I didn’t go through that. But both of them, are pretty effective, like I said, this one [DSM diagnosis] is more clinical, more medical type. And, that one [EPCP], the other one kinda—I’m a big mythology buff, so that one can be a little more, it’s more...I could say, ‘Yeah, that’s me and it’s this guy also, you know what I'm sayin’—like Odysseus or Zeus or somebody like that. I could look at that one and say, ‘Well, Zeus has these problems too, you know, Odysseus was stuck out at sea because of this reason, he met Poseidon there. That one [DSM] appeals to, I don't know a medical term for it, but it just more, a little kind—I can pick that one up [EPCP] and kind of read it and say ‘That’s a pretty interesting character, I want to find out more about him.’ This one [DSM] you know what I'm sayin’, it’s kinda more hard nosed you know what I'm sayin’, but I agree with both of them, ‘cause I love medical talk.” Although Simon had some difficulty in responding, partly because he was trying to compare the diagnoses and partly because he did not want to offend me (three of the four participants worried about offending me, as they could not be sure which one I espoused), a few issues arose. First, Simon was very aware of the origin of the diagnosis, probably due to a combination of his inquisitiveness as well as the omnipresence of the DSM in this setting. Second, he characterizes the DSM as more clinical and medical. Third, the experiential diagnosis, for Simon, reflects uniquely human struggles. Lastly, it can be inferred that the DSM diagnosis may be more pathologizing, as the experiential constructivist diagnosis reflects a person that he likes.

I said that we could go through the same process as we did with the experiential constructivist diagnosis and then try to compare the diagnoses. I asked the first question on my list: how the diagnosis conceptualizes his strengths and weakness. Simon reflected upon the nomothetic nature of the DSM diagnosis: “Well this one seemed like it was talking more in general—kinda like if you were trying to recruit a certain type of people, maybe for a study...this is what you would print out.” Simon paused before reading from the diagnosis in a
low and sarcastic tone, “Positive symptoms, distortion of normal functions.” After pausing for a moment, he continued, “I guess I could argue more with this one [DSM]. ‘Distortions of normal functions.’ What is a normal function? I could play the devil’s advocate with this one more than I could play with that one. I could question the structure of it. It’s not as malleable as this one [points to experiential constructivist diagnosis] is.” For Simon, the diagnosis general level of description was connected to notions of what constitutes normal experience. While unclear at this point, Simon’s feels as though the implicit definition of normality and abnormality promoted by the DSM diagnosis was not as universal as assumed in the DSM.

He continued, “I feel like I’m an individual and the things that make me who I am are not medical definitions—and this one is kind of like white suit coat, kinda lookin’ in the fish bowl, lookin’ in the lion’s cage while the lion is in the cage. Saying, ‘Oh, he’s from the genus yadda, yadda, yadda, he consumes fifteen pounds of meat a day, by the time he’s five years old he will have grown to his full.’ This one [experiential constructivist diagnosis] is kind of like more hands on; you’re kind of like in the cage of the beast. The lion is getting to know you a little bit and you’re getting to know the mannerisms of the lion, you know. This [DSM diagnosis] is kind of like, stand back, ‘It is a typical black male, came from a broken family,’ kind of a little further off, a little stand offish you know.” For Simon, the DSM diagnosis did not overlap with his conception of who he was as a person, as medical descriptions divide the world into those who are normal and abnormal. Furthermore, when discussing the DSM, he saw himself as akin to the lion, depriving him of any humanness. Like the lion, Simon was locked away due to his aggressive and inhuman behaviors. Those who fall into the normal group not only have the privilege to look into the cage and make observations about the animal, but never get to know the lion. It appears as though Simon feels a medical definition of his struggles only serves to rob him of a sense of individuality. Conversely, the experiential constructivist diagnosis allows others to enter into the cage. While dangerous, the lion and the hypothetical therapist can learn about one another and form some type of relationship. However, Simon refers to himself as a caged animal, implying a fundamental disconnect from others, possibly an artifact of living in a locked inpatient facility.

As Simon said he could argue with this diagnosis more, I invited him to do that. He replied, “Yeah, I mean, just like, ok, it says ‘Positive symptoms appear to reflect an excess or distortion of normal functions.’ And, then I say, ‘Well, what's a normal function,’ you know,
and that’s why I was kinda interested in your background a little bit, so I could—because normality—I think for the most part anarchy rules the universe. More things go wrong than go right. When you use a term like normalcy, it implies a lot of weight. Normalcy—that’s kind of like dominant white male type, this is the way it should be you know, and…”

“Not the way it is but the way it should be,” I offered. “Right and in most cases normality is a rarity you know, I mean, two parents, housewife for a mother, 3.2 kids, whatever, middle class, grandparents, you know what I’m sayin’. So, that’s not normal and that’s not what I saw everyday when I came out my house. So, to say something like normal, it’s one of those words that kind of makes me send up my red flag ‘cause that’s something I’m looking for. So I’m saying, ‘Well you got to this road. Did you see that sign, ‘cause I saw it?’ And, if you say, ‘I didn’t see it’ then I’ll put that back in my backpack and say, ‘Well, I’ll wait to the next one to see if that’s normal.’”

I reflected that it weighed him down to have to put things back into his backpack. “Well just that little bit of—the opportunity, in passing, is a freeing experience, you know what I’m sayin’. Just for that moment. ‘Cause, we are controlled by our senses. The eye continuously wants to see things, you know. I mean you can try to shield your eyes but if you are not normally blind, initially, you’re going to open them and you’re gonna be bombarded with the visual sensory, you know what I’m sayin’. Just to say, ‘When you left this room did you see 65A [sign on the office door]?’ ‘Aww, I saw that too, what did you think? Was it this was it that?’ Just to make it more tangible. Maybe I had—maybe the idea of normality is a myth here in America and I recognized that I didn’t fit in these neat categories as a young child, you know. So, I began to take on maybe, antisocial behaviors because I knew that that idea of normality was never going to fit me. So, I began to act out, explore alternative ends to, to the human experience and try to say, ‘Well, this doesn’t fit me so I’m going to go this way.’ Eventually I’m going to get rid of this package and I’m going to be free. But, I can’t take the path of normality ‘cause that doesn’t fit me. So, I think I realized that normalcy didn’t fit me at an early age, you know, so I began to—and this is why I need help. Where are my antisocial behaviors? Where do they exist? Did they come with my drug use or is that something that’s normal?”

Simon felt that the dominant perspective did not provide a viable path for him. In his statement, Simon began to question the nomothetic nature of the DSM diagnosis. The issue of what can be considered normal behavior (as well as the equation of normal with healthy) is the
basic problem with the “structure” of the DSM diagnosis. Simon seems to have an acute sense of how his experience did not overlap with dominant Eurocentric culture. In taking an alternate path, he has had experiences that seem foreign to others, helping Simon construct an identity around being a social outcast. I commented that it sounded as if this alternative path, while obscure at times, was more meaningful for him, as it was the basis for his sense of identity.

Simon replied, “Well, when I got older, I began to purposely try to do things that Jesus the Son of Mary did, ‘cause that was considered normal. That was one thing that a lot of people in my neighborhood were doing. Christ-like you know, which is what Christianity teaches, be like Christ. So, I figured out that I didn’t fit the normal category and Jesus kinda didn’t fit the normal category. I’d get to a sign and I say, ‘Well, what would Jesus do?’ I could look at that sign and feel like I had a way to touch it. Because I can’t touch normalcy on my own. I’m an outcast. I knew I didn’t fit normal but Jesus kinda was an outcast, too. So, I would go off and read my Bible: ‘Hey Jesus, that’s 65A, what do you think about that?’ And, then things started happening. I started feeling like, ‘man this is what Jesus went through.’ That’s cool, I wouldn’t say a déjà vu, more like eureka. I found it, I get out, I get kicked out of a church, and as I'm walking home from the church, I'm thinking, this happened to Jesus. Eureka, that’s pretty cool. I’m getting to what's normal now ‘cause everybody’s trying to be like Jesus. Jesus got kicked out of a church, I got kicked out of a church, that’s pretty cool. Jesus talked to prostitutes and tax collectors. They were the outcasts of his society. I lived in Florida with prostitutes and cocaine addicts. That was kinda what Jesus would do. So I'm looking at that sign and it gives me power over that sign, because now I’ve got it plus Jesus has it. So, we can drag it and say this is what normal is, that’s not what normal is. So, I can kinda touch it more, I can use more of my senses ‘cause before, before I had Jesus, and it was just me—it’s like, I don't know shield yourself from the fire and brimstone because you can’t touch it, but it’s there. It’s more mine now, you know, I own it. And, I don't know if that’s Anglo-Saxon desire to own something. ‘I paid the Indians 16 guns for a hundred acres of the Louisiana Purchase.’ I own it now, you know. I came out the womb, I didn’t own anything, but everything around me said, ‘Ownership. Own this. Own this.’ And, I'm like what am I to do, I don’t fit in. I don’t own anything, my grandfather doesn’t own anything, my father doesn’t own anything. What am I to do: antisocial, you know what I'm sayin’. But, then, my antisocial behavior there were a few kinda solid ideas you know, Bob Marley, Jesus Christ, these were men that said, ‘Hey, I'm antisocial too.’ But, I
took that sign when I came to it and it’s mine now. That’s normal, you know what I'm sayin’, so pushing normal back a little bit, saying this is reality.” Simon describes having difficulty integrating the different perspectives he has experienced (e.g., his parents’ opposing spiritualities). He views his own behaviors as antisocial, even though he can point to symbols from mainstream culture that overlap with his experience.

“The concept of normality is more hurtful than it is useful for you.”

Simon agreed and mused that he was a masochistic person. “Maybe I get a kick out of going the hard way around. That’s one of the reasons I open up, so I can hear someone say, ‘Man, you just a glutton for pain,’ but here’s someone else saying that instead of me just saying it to myself, you know.” The theme of taking the harder or more difficult route in life appeared numerous times in our conversations. When others note that the path he had chosen is more difficult and that he enjoys these pains and struggles, it validated the choices he made to put himself on a different path. Additionally, Simon equated the medical model with normality.

He continued on this theme. “I don’t wanna pay into this idea, this medical, this clinical description of who I am, I kinda wanna move as far away from it as possible. I want my experience to be experienced by people after me with people that wanna touch, that wanna feel and see and embrace, rather than, ‘This is schizophrenia, the paranoid type.’ That type. I don’t want clinical. I want ‘Man, he came past this sign and he had a bad day. He went back to his room and wept for a few hours. But, then he picked himself up by his bootstraps and went out there and wrote a writing from Nietzsche, ‘God is dead.’ Something, to make it easier for other people that, when they sit in this seat, they can touch the things and say, ‘Ahh, we are not blind, we’re not blind, we do feel, we do experience.’” Again, Simon recognized the medical model’s understanding of him but choose to define himself in alternative ways. Additionally, he felt objectified by the DSM diagnosis. His humanity, his ability to see clearly, to feel and to experience, is stripped in favor of a diagnostic category. There is a striking difference between “schizophrenia, the paranoid type” and “he went back to his room and wept.” The second description does not abide by what Simon perceives as the DSM’s distinction between normal, or healthy, and abnormal, unhealthy. Simon’s felt as though his experience could not be reduced to a label that ignored a description of the pain and loneliness he experienced alongside his courageous attempts “to pick himself up.”
I asked him if there was anything else he wanted to convey in terms of the strengths and weakness of the DSM diagnosis. He replied, “I mean I like it because it kinda represents the old order. Kinda like the last of the Mohicans. Something that’s dying away—like a dinosaur. That’s kinda how I look at it. I can look at it and kinda say, ‘Ahh it’s flawed.’ Like I said, I think they are both necessary. I don’t know—here we are in this room—I lost my train of thought.”

I said that the two diagnoses each offered different perspectives, and that he valued both, but that he did not feel comfortable with some aspects of the DSM’s description of him; namely, the issue of normality and what it meant for him.

He replied, “This one [points to DSM diagnosis], I can touch it and say, ‘That’s wrong. That’s not me. It says normal functioning.’ It’s flawed, you know what I’m sayin’, I can maybe recycle this [DSM diagnosis], you know what I'm sayin’, but the less tangible one [EPCP diagnosis] I have to rely on something bigger than me to guide me to understand it. I can’t touch that one. This one I can touch and I can say—I mean, if you believe there’s an ultimate good in the universe and there’s an ultimately bad, I can say this [points to DSM] is ultimately bad. And, this [points to EPCP], coming into contact with this, validates my leaving this path, ‘cause this [DSM diagnosis] is ultimately evil because it purports to try to understand things in a way this is deceasing, it’s dying, it’s fallen by the side. So, this [DSM diagnosis] is kinda like Lucifer, and that one [EPCP diagnosis] makes me believe in something bigger than myself, ‘cause that’s [EPCP] more me than this [DSM], that’s [EPCP] more of my flesh. This [DSM] is not my flesh. This [DSM] is something that is not going to be here eventually. I’m pushing this back underground and I’m trying to fertilize the earth with that.” Simon seems to think that the DSM diagnosis is something that, while tangible, is not him. He may be able to recycle the perspective of the DSM into something that fits him better, but, in the end, it represents a perspective that he actively tries to reject. For Simon, the DSM diagnosis is a flawed perspective of human struggles that ultimately will be left behind. In contrast, the experiential constructivist diagnosis feels alive to him. While it is just words on paper, it feels like part of his own corporeal self is on paper. Lastly, to believe in the experiential constructivist diagnosis, he must believe in something larger than himself. The DSM diagnosis, in its focus on individual deficits, may further Simon’s sense of alienation from others.
“What else doesn’t feel so comfortable for you,” I asked. While I wanted to be sure of what he said, my question may reflect my bias against the DSM.

“Let’s see,” Simon begins to read from diagnosis, “Positive symptoms appear to reflect an excess or distortion of normal functions. We have positive symptoms and normal function. What are normal functions? They include distortion of thought content or perception and self monitoring. I underlined distortion of thought, perception. Distortion of thought, you know what I'm sayin’. Every Sunday, for the first fifteen years of my life, I was almost definitely in church—where a figure I had access to, stood in front of the congregation and said God is real, there is an ultimate good in the universe that created all this around us, everything: the grass, the air, the light, the sun, the stars, everything. Ok, now I go down the road a little bit further and I meet somebody that says, ‘I’m an atheist, there is no such thing as God.’ So, what is a normal perception? Is there a God or is there not a God? What’s normal? There is nothing in here that says there is no God and this is why. There is nothing here that says ‘Well, to be normal you must believe in a God.’ I don’t know what normal is, distortion of thought and perception, I don’t know what those are.” Simon continues to problematize the DSM assumption of normal. Using an example from his life, he demonstrates how difficult it is for him to assume an uncomplicated understanding of normality.

“What’s the part about this, I mean you compare it to the devil, what is the part of this that is dying off?” I asked.

“Well, somewhere in my upbringing, I rejected social norms, I rejected Leave it to Beaver and Little House on the Prairie. I rejected these icons that were beamed into my household. Because when I came home, Mom was at work, Dad was at work. So, I’m watching TV, lunch is not prepared…I guess I kinda picked up on it, like white supremacy. I kinda, somehow in my brain, that’s what was being beamed to me, white supremacy. I began to see the holes in this ideology and so, I began to say, ‘Do you believe in God or do you believe in there is no God?’ Kinda shoot holes through this European idea of what is normal. Opened up that Pandora’s box, I opened up a parallel dimension. To, what’s normal in my community? So, I feel like the Anglo-Saxon ideal of normal and good and pure and whole, these notions that I was bombarded with everyday, didn’t fit me. So, I began to rebel against them. I began to look for opportunities to justify my outcast status. I began to, so I’m trying to move in on this, what I perceive is a passing legacy, there is something that’s gone away: an old world order, you know
what I'm sayin’. Something that’s shooting itself in the knee by asking the questions: What’s real? What do you believe in?” Simon’s images of popular culture reflected a European, Anglo-Saxon ideal, not the reality he saw in his daily life. He attempted to find ways to validate his feeling of being an outcast in trying to reject the ideals. *Furthermore, merely asking the question of normality is dangerous, as it implies that there is an ideal, something that can be used to subjugate others and create outcasts like himself.*

I moved to my next question. “Using this diagnosis, how do you understand personal change and the future?”

Continuing on this theme of being an outcast, he replied, “It kind of allows me to say I have a job in the future. When the world starts downsizing, I will have a job because I have been questioning this world order, this perception for years. As long as this is alive, you know what I'm sayin’, I’m going to have a job of questioning what this is and what it purports to be understanding—its status as truth or knowledge. I have a job, to question this, so it allows me to say well I’m going to be, there’s going to be sustenance for me. That is all I can hope for is sustenance, you know what I'm sayin’, be it a good friend or material worth. As long as this exists [points to DSM diagnosis] I am going to have a job. Question it, question it, you know.” It appeared that Simon saw the perspective of the DSM as congruent with that of the cultural at large. I asked him to say more, as I did not want to assume too quickly the meaning of his words.

Simon said, “Well, I mean this represents European thought to me. It represents a political/social agenda that I feel is a false truth. It’s not life; it represents death. So, as long as death has a place in this universe, I’m going to have the job to put it in its grave. I’m going to have the job of casting Satan into Hell and trapping him there. I am going to have that job as long as this exists. Now, if this idea takes root [nods to EPCP diagnosis], you know what I'm sayin’, and this model of the universe takes place or is embraced instead of this one [DSM diagnosis], I may not have a job. But, then again I’ll be fulfilled, because I won’t be an outcast. I will be accepted. There will be a seat for me. I will have place. I don’t have a place in this one. Yet, I still do have a place—to stand against it.” It becomes clear that Simon equates the DSM diagnosis with a Eurocentric perspective that he had decided to reject. Furthermore, the DSM gives him the status of cultural gadfly. In many respects, Simon’s position can be understood as a protest against the values of mainstream American culture. The experiential
constructivist diagnosis is something he is working towards and, if such a perspective were embraced, he would be fulfilled. He no longer has to be the social outcast.

I asked Simon if the DSM diagnosis creates outcasts. He replied, “I wouldn’t necessarily have thoughts about—well—hmm, I mean it depends if it is a psychiatrist who came in and at the end of this [nods towards DSM diagnosis] and says, ‘Ok, here’s your month supply of Zoloft.’ I’d probably brush him off. I might try to give him a hard time. I might be a smart-aleck or something like that, you know what I'm sayin’.”

“And if he didn’t prescribe medication.”

“Ahh, and said, ‘Next time we come together, we are going to chew cud, we are going to talk about world events, just kinda walk through the garden of life, kinda celebrate life.’ It’s a cold world and [let’s] try to build a fire to warm each other, so we can run back to the cave and get more people to come and warm themselves by the fire. And, pretty soon we’ll—there will be a revolution, we’ll be overthrowing the old order, if we just keep coming back to the fire and warming our hands and saying, ‘Hey! I’m over here. It’s a life giving fire here, let gets warm.’”

“So, if this person you are talking about, would be able to go there with you, it would be alright that he is looking you in this way.”

“Yeah, yeah, yeah.”

“So, it really comes down to…people can use different theories to understand people but it really comes down to the person themselves that you are sitting with.” Simon does not understand what I asked him. “It seems like you are saying, ‘I’d be ok with someone seeing me this [DSM] way if they are willing to talk to me about it.’”

“Yeah, yeah. I mean I feel comfortable, I feel like I only know my own ignorance, but I feel like I could understand this enough to, I can talk to you with this being the focal point. I could use this, but I would rather go about it another way. This is cool, because I feel like I can wade through the medical terms, it’s still a useful tool.”

“What occurs to me, is could someone that thought this way think that you could move beyond your struggles and change?”

“I think I am already set in my ways so I’m really not changing, you know what I mean. I’m trying to make sure that the fire I’ve got is really burning. So, I got this little torch I’m holding over here…I’m not, I feel like I’m at the point now where my sole job is to bring people out of the darkness to get them around this fire, so it’s not necessarily change. Is he going to be
satisfied with this fire? If not I can take my fire elsewhere, I’m not really here to change. I feel like I’ve saw the options and I’ve already chosen my poison, so I’m just saying, “I’ve got fire. Come check it out. If not, you know what I'm sayin’.”

“Let me put it this way. We were talking before about running the race, working with someone…Change is a loaded word in a lot of ways. Does this person think you can go off and run this race? You know, engage in therapy with this person, then does this person trust your ability to go out on your own.” I said, feeling as though I pressured Simon.

“Ahh, I think that would have to come from the clinician. I think that is something they, I don’t know, maybe we was missing, maybe we missed each other or a couple of key ideas to where they didn’t, they may not know my historical/political situation as it relates to these ideas. So, maybe they were, maybe they began to feel comfortable with these ideas, when I began to reject them, so maybe it was a—I don’t know.”

“A mismatch in a way. They are feeling more comfortable accepting these ideas, you are feeling more comfortable rejecting these ideas and this [Simon: Right, right] results in mismatch…so, you two could have conversations, but he or she may not understand your historical position in your, and I assume by historical position not just family history, you mean broader than that, political context, historical context, living as a black male in this culture and the affects of living in a predominately white culture. This historical political piece is going to be lost in here.”

“It’s real, ahh, rigid. It’s not as abstract, you know what I'm sayin’, I feel for one to be, maybe successful, in this universe, one would have to be flexible and contort and shift weight, and to bend and move. To be a child of the universe, where this one is concrete and solid, the first one is more abstract, you could turn it this way and turn it this way to this way, this is more solid. What was that—Plato? With the allegory of the cave? This—I’d better not say that cause I’m not too familiar with it, but it, this first one [EPCP] is more flexible, the second [DSM] is more rigid. If I embrace this [DSM], I feel like eventually I’m going to be destroyed because its going to keep me from being able to move, it’s going to be my death ultimately. This [DSM] says the white male perspective of history for the past, at least 2000 years, has been Anglo-Saxon, European, I don’t know, right wing. These are ideas of morality, these are ideas of normality. You don’t fit into this category, normal, and my god that led us to reasons to, that’s on our money, that’s on our license plates, is going to crush you…So, if I embrace this, it’s like
I’m embracing death. There won’t really be comfort, when this idea [points to DSM diagnosis] rules the universe. This flexible one [EPCP diagnosis] will be a cover for me, will be a jacket, will be a roof when this one is in authority.”

“You spoke to this a little before, but how do you see this one [DSM] in terms of being effective for you, the second therapist.”

“Like I said, it would keep me with a job. As long as this one is embraced, I’m going to have the occupation of protestor, mounting a revolution against it, I would be employed. I would be the one who has fire. As long it exists in authority I will be protected by number one [EPCP diagnosis]. I have the duty to continue to bring people to the light and say, ‘Well that idea, that social program is not going to work. It’s going to fail. Come sit by the fire. Embrace yourself.’ So when the wheels, the mechanisms, the inner workings of this idea, when it begins to jam up, you’ll have some cushion from the fallout, you know.”

“Would your ability to trust this therapist change because they were using that one?”

“Nah, because I believe everyone is here for a reason, everybody has a purpose, everybody has a viewpoint and I’m to the point where I mostly listen, you know. I mostly listen because maybe my fire is going out a little bit. I need to find somebody with fresh legs. My legs are about to come to end. I’m tuckering out, so I need to kinda listen so I can gravitate to the next person with the fire.”

“Do you think this person would be limited by understanding you through this?”

“Nah, because I think I’ve been given the ability to speak clearly on this area. I feel like I can speak intelligently enough about the two ideas to where that person could, you know what I’m sayin’, say, “True.” If I say something, they could say, “Yes, that is 65A” instead of something else. I feel like I’ve embraced enough of the literature, literature in general to speak intelligently, to where they’ll say somewhere in their day, or in their week or in their month or in their year, they will say, ‘Ahh, that reminds me of Simon.’ That causes a domino effect somewhere to eventually, this [DSM diagnosis] would be dislodged and that one [EPCP] will be embraced or it will destroy them. I feel like I’ve been blessed to rotate toward universal truths that are easy to see that are not real mystical and hard to grab. ‘Yes, that is 65A.’ If you walk out of this room, ‘That Simon, what’s he doin’ right now?’ That will continue the spark until it knocks, dislodges this one from its importance and the other one will come. I’m going to like my tears.”

65
“Says something about suffering that is important. Do you feel victimized at all with that one?"

“Victimized? I think the reality of victimization is something that you have to kinda understand if you want to be beautiful, if you want to be complete and whole and safe and responsive to the beautiful things in the universe. You have to, like I said, this is a cruel world, and for the most part, chaos is ruling. Chaos is the order of this portion of the universe we call home. So, you have to, you have to give before you can receive—it’s better to give than to receive. So, you have to be able to expose your heart or your loves to unravel the mystery of those loves ‘cause they may be wrapped in an ugly package. So, you have to say, you have to set out your best china when anybody comes over to eat. You have to put out the best, you know what I'm sayin’. I try and I hope that I will continue to evolve to say, ‘It’s not victimization, it’s me giving of myself.’ To say that I’m being victimized, it’s, I think it’s to miss the beautiful of the universe, which gives and which burns and it turns and it caves, but something has to, a seed has to germinate before it can produce fruit. So something always has to be sacrificed, you know what I'm sayin’. Abraham was going to sacrifice Isaac and God sacrificed the animals so that Adam and Eve could cover themselves. So, if you want fruits, you have to put seeds in the ground that have to die or germinate before they can bring forth. So you have to psychoanalyze yourself and chop yourself up in little pieces and say, ‘Well, here, I can set this out. It’s good. It’s me. Take it. Do what you will with it. You can’t harm me cause I’ve set out my good stuff.’ So, if you take advantage of that it’s not lost to me because even if its taken and misused. It will bring forth something beautiful in the end, so I don’t think either one is a victimization ‘cause I feel like I’m giving. So, I am a gift giver. So, I feel like it’s harder for me to say victimization.”

“Do you prefer one over the other?”

“I feel like, number one [EPCP diagnosis], it’s my responsibility and, number two [DSM] is a source of—it’s an occupation. I guess I want to have more experiences that are akin to the first one, more so than the second one. But, I think they’re both without evil. I would say one [EPCP diagnosis], but I can’t say one without the other. Because it’s kinda like the ying and yang to where you have an ultimate good, but in the good, there is a little bit of the bad, so, so, I don’t know if there is separation between the two. I like both of them because I feel like without one I couldn’t have the other. I guess I just called myself a schizophrenic, I have a split mind.
One side is European, the other side is community, familiarity, home. So, that could be drawing parallels of not having a physical home, to be in a foreign land, to be away from your own country, to be away from your own continent, your own community. We run with everything, Americans like to run, with patriotism and love for their country until it knocks you out or trips you up. When you say, all that running, I can’t displace it, because it’s been controlling me. I have been under the influence of that time period, under that historical view of the world, and it hit me and it hurt. So, in that pain, I began to long for a place that was more soothing and warmer, yet at the same time, it gives me a sense of purpose like that when I was running with the American flag. So, it’s like being trapped in between two flags, you know, two ideas, two ideologies. So…”

“So, it’s kinda like you are saying…the both exist in the world at this point in time…”

“I mean cause, I feel like, you know what I'm sayin’, it’s dominant and it’s submissive. I got to the point where dominance became an abnormality. It was not normal because I began to see flaws in its structure, so I kinda gave up, and became antisocial, so whenever I see the word normal, I think of the first five, six years of my life and think how alone, and longer than that, actually in between 13, where I was under the spell of capitalism and democracy, the European ideas of power and morality.”

“Does one give you more hope than the other does?”

“Well, I guess to answer the question of hope, I would have to be satisfied with my idea of normality and I haven’t yet. I still am looking for what it is to be normal. So, I’m sayin’, this one, the first one says, maybe eventually you will understand what normality is, so there is hope in that one. And, yeah, its hope that I will be able to say, ‘Yes, that’s normal’ and I can began to fulfill this one [EPCP diagnosis]. I’ll be able to plug normal into this equation, and I will be able to bring life to that which is dead, once I figure out what normal is. Is there a God? Isn’t there a God? I can plug this in and say, ‘Ok, normal is there is no God or there is a God.’ So, I guess there is hope. That’s why I believe in this one too cause it says that maybe there is a normality, maybe that which is dead can come alive again. So I’m like trying to get to my ancestors and my heroes that have passed away. And, I feel like this will be a vehicle to bring them back cause it says, ‘One nation under God, indivisible, with liberty and justice for all.’ Jesus died, he’s going
to come back and bring back all those that loved him, I loved him, I think Bob Marley loved him. We’re going to bring all those people back, and we are going to sit by the fire that we’ve been warmin’ ourselves and have a big pow-wow on the beach or something like that. So, this [DSM] one gives me hope that I can fulfill this [EPCP] one, I bring this [DSM] one back alive. It’s not a dead language, it’s not a dead ideology, you know what I’m sayin’, it can be complete, but right now it’s incomplete.”

Fourth and Fifth Interviews. I had the opportunity to meet with Simon for two more interviews. We found ourselves out of time but we had not been able to discuss the purpose of the study and I could not adequately debrief him. The fourth and fifth interviews also served as opportunities to continue to see how Simon’s thoughts about the diagnoses changed over time. Simon continued to prefer the experiential constructivist diagnosis. Furthermore, he validated the diagnosis by bringing in more experiences (Leitner & Guthrie, 1993). I also observed a shift in Simon sense of self, as he began to see his experiences in a different light, further confirmation that the diagnosis was useful and, in many respects, therapeutic for him. For instance, Simon began to feel anger around his parents’ treatment of him. He said,

I had it all [previously discussing some experiences of self-realization]. But I’m mad at my parents for letting me do that. For spoon feeding me this reality that would, would never work. I might have took a different path if they would have separated, you know? I would have continued trying to pull them together. ‘Cause that’s all a kid knows! Is his parents, you know. ‘Ah, mom does this, dad does this.’ They don’t, they don’t go together, but somehow I can do it. ‘Cause I am the sum of that product. I mean, I am I am the sum of that mathematical equation. Susan plus Fred equals Simon. I can do it. They never, my mom never said, ‘You’re daddy’s this, you’re daddy’s that. Don’t follow him.’ Well, I guess she did. My dad never said, ‘You’re mom’s this, you’re mom’s that.’ I mean that’s all a kid knows. I wanna be like my dad, I wanna be like my mom. I like these things, how can I make them work together? And I did it. As unnatural as it probably is, I did it, you know. You know? I did it, you know, I made it, you know? So, I crossed the finish line…I paid for crossing that finish line first, you know? And now, now… the desire to try to pick up a few of the pieces that’s left. That’s all I have. And it’s not worth it. If I would have known that my end would be here, I would’ve cancelled trying to bring them two together a long time ago.
Simon’s anger can be seen as movement in relation to the ease with which he previously forgave them. Furthermore, he began to question and to see how his parents affected his life. In many respects, it can be said that Simon is beginning to develop some responsibility for his construction of the world. As the discussion around the experiential constructivist diagnosis promoted some change, the diagnosis itself was therapeutic.

Janet

Janet was a 45 year old, Caucasian woman who had been admitted to the hospital a few weeks before we met. The last few years of Janet’s life had been tumultuous. Many of her struggles intensified when her husband, an emotionally, physically and sexually abusive man, began to cheat on her with other women. As Janet began to struggle more psychologically, he divorced her and cited her psychiatric struggles as the cause of their divorce. Because of Janet’s struggles, her husband was awarded custody of their 13 year old, developmentally disabled son. Janet was enraged, as her husband took little responsibility for their son’s upbringing while they were married. According to Janet, she was admitted to two treatment facilities before she was transferred to the facility in which we met.

Janet and I met for three interviews: one intake interview and two research interviews. While we scheduled one research meeting, we needed to split the interview into two sessions because Janet was very distressed the day of interview. We originally decided to meet on a Saturday because there were not many activities planned on the weekends for patients. While she was eager to speak with me, she often could not focus on my questions and grew angry, sad, and tearful. We stopped and started the interview a few times that day and, as the evening approached, eventually decided to meet four days later. Janet had grown increasingly distressed at the hospital because it did not feel like a safe environment for her. I tried to comfort Janet as much as I could, without intruding upon her relationship with her therapist, someone who would be at the hospital longer than me.

Janet was a very slight and soft-spoken woman. When she spoke about horrible experiences, her face would contort as if took all her energy to suppress the anger and desperation she felt around these events. At times, Janet’s soft spoken and quiet demeanor would fade and she acted in an angry and aggressive manner. As I never saw her at these times, it was difficult to imagine what such scenes would look like.

Diagnostic Interview. I began the diagnostic interview by asking Janet to tell me about
herself. She then told me where she was from, and she decided to begin with her childhood:

“My childhood is pretty good. My dad had a bad temper, and sometimes he was abusive to my mom. I remember one time he was to me and I kind of inherited that temper, which is why I’m in anger management classes and why I’m here at the hospital. Other than that, I had a pretty good home life. Our family is close now and we’ve resolved any problems that we were having in the past.” Each of her sentences seemed pregnant with meaning that stayed just below the surface of Janet’s quiet exterior. Aside from the notion that her childhood was “good” yet “abusive,” Janet began the discussion in the present tense, as if her childhood had not ended over three decades ago. The way she understood her struggles with anger as being inherited stood out to me, and I stored this away for future reference. I could not help but wonder what Janet meant by her statement that her family resolved past troubles. *Furthermore, it appeared as though these painful childhood memories were very much alive for her and the pain made it difficult to experience past and present as distinct.*

Janet continued, “After I graduated from high school, I attended college for music education. I taught in schools for a couple of years. Then I got into, I play piano by the way, and then I got into teaching piano lessons and I eventually became education director of the music center in our town. I was in charge of the music studios there, hiring the teachers and ordering music. I had about 40 students in all that I taught. I quit my job there and became a secretary at the high school. I worked for the government for about a year or so. Then I went back to the music center and I became pregnant with my first son. After he was born, I quit and stayed home with him—I’m a stay at home mom, and my husband works—we are lucky enough to do that. Um, our son is autistic—” *At this point, it appeared as though Janet understood herself as a variety of roles and described each of these as incidents that occurred to her, as if there was little agency in constructing life events. She also speaks as if she was still married.*

I acknowledged that she had mentioned her son was diagnosed with autism. She explained, “Which means part of his brain doesn’t function properly, in the areas of social skills, communication and reasoning. Right now he is in the hospital [in a city a few hours away] and he’s been on medication. He’s thirteen and going through puberty, so we’re struggling with some behavioral problems. He’s getting up in the middle of the night and playing with the stove and that sort of thing. So, as far as I know, he’s still in the hospital. My husband and, I, um, because of my, because of my—September of 2004 is when I began having panic attacks. That’s
when my illness started and just seemed to get progressively worse. I was hospitalized a number of times, and my husband couldn’t handle that. He ended up having an affair and we got a divorce. He has custody of our son and they moved away and I haven’t seen my son in probably a couple of months now.” Again, it appeared as though Janet described events and experiences, as if people had little agency. For instance, it somehow made intuitive sense that her son would wake up and play with the stove because he was going through puberty. It also made sense that her husband would leave her because she had an illness. *Another interpretation of this statement could be that Janet took all of the responsibility for her divorce but verbalizes her struggles as illness based.*

“That must be difficult, to not see your son,” I replied.

“Yeah, at first, my stay here went really well. I was able to control my temper tantrums and not get angry. But, now, I’ve been having a little trouble. There were some issues that came up that caused me to get upset. Plus, I want to go home. I don’t want to be here, and that’s caused a few crying spells…I’m supposed to stay three months because I’m here on temporary commitment, but I’m hoping I’ll get out after the three months. But, after this past month, I don’t know, I may have to end up staying longer. I don’t know.”

“What sorts of things have upset you?”

“Well, they are kind of personal things—I had a hysterectomy this past January, and I have a vaginal discharge to where I need, I feel like I need, to wear panty liners. And, the doctor seems to think that I don’t need to wear them. He only wants me to wear three of them a day. He’s making me, I feel like,” Janet paused and tried to contain her rage before she continued, “and, even my therapist brought it up in my last session. I got very upset because to me that is such a minor, minor issue. All I have to do is give money to my social worker, and she will go out and get me some [panty liners].”

“Sure, yeah,” was all I could really muster, as I found myself concerned as to why she was having vaginal discharge five months after surgery.

Janet’s face contorted as she became visibly angry. “And I can use them. You know, if I was on my own, I would go out and get them. That’s what they’re there for. They are making more of an issue of my panty liners than they are regarding my treatment. And, since I’ve been here, I’ve only been with my treatment team twice and they really don’t have much to say. I don’t even know what my treatment plan is. So, I’m just very upset with the doctor.”
“That’s understandable,” I answered, again unsure of what to say.

She continued, “Other members of the staff also seem to think my panty liners are more important than my treatment. And that’s very aggravating to me, and that’s what caused—I did throw a temper tantrum in my therapist’s office the last time I met with her ‘cause she kept dwelling on that subject. And, I was made to go to the med-clinic and have an examination regarding the discharge, but we haven’t gotten the results back from that yet. That’s been very upsetting to me. The only time the doctor has really sat down and talked to me is regarding the panty liners. He is not very nice about it—he’s very blunt about it. I even wrote out a patient complaint form regarding this because I feel like my treatment is being neglected because of this issue. It does really upset me, just thinking about it now, I want to get upset about it.” Janet seemed to feel increasingly neglected and alone, but she had trouble saying she felt neglected and instead referred to her treatment being neglected. Whatever the basis for her need was, the staff’s focus on her panty liners caused her great distress. It concerned me that the staff would not relent in the face of her distress.

Janet continued to describe what had been troubling her recently. “I got a call one night to say that my son was in the hospital for the third time and that upset me as well. It brought on a crying spell, and I couldn’t settle down. And, they had to give me a shot. I love my son very much and I miss him very much.” At this point, I found myself angry at the hospital staff (possibly taking on some of Janet’s anger). Her response, regardless of intensity, seemed like a wholly appropriate way for a mother to respond to hearing troubling news compounded by her feelings of loss and simply missing her son. Their response, however, seemed excessive to me. Not only where they invalidating her love for her son, they appeared to chemically bind her to the hospital as they invalidated that desire to leave. As she continued with the next thing that was troubling her, I found myself feeling angry, frustrated and hopeless and had some trepidation about what could possibly come next.

“And, there’s another thing that’s upsetting me. There is another client on the unit that liked me. He and I would go for walks together and it seemed to be—we liked each other well enough, but I told him I didn’t want to go as far as any sexual relationship. I made that perfectly clear, and he molested me the other night, a couple nights ago. I called the nurse, and security came in and took a statement. They talked to me a couple of times. And, things just haven’t been going well for me this second time. I’m afraid that it’s going to affect the amount of time I
spend here because I’ve been getting upset so many times. I feel as though I have good reasons to be upset, but I don’t feel like I’m getting the proper support and the proper treatment for my illness. My therapist back home says I have borderline personality disorder. I have trouble with anger and I throw temper tantrums when I don’t get my way or I don’t get something I want right away or if something upsets me, I get upset, if something happens I get upset. That’s why I’m here and I had been here a month and a half before I even started on any kind of treatment for my anger. I was watching Richard Simmons doing sitercise while I was waiting to get my schedule and my treatment plan all lined up. I feel like now I’m finally getting into it. I’m taking the anger management class now. And, I’m also taking DBT (Dialectical Behavior Therapy; Linehan, 1993) skills training classes. I have those four times a week and that’s supposed to help me with my anger and with my emotions and that sort of thing. So, I finally feel like we are starting to get somewhere, but, I’m really afraid I’m going to have to stay longer because I’ve been getting so upset. But, I feel like the reasons I’ve been getting upset have been reasons that could have been avoided.”

“That seems a very legitimate reason to be upset,” I replied, but it didn’t appear that Janet had heard me. “Because I was doing so well the first month. And, I feel like if it wouldn’t be for these issues that have come up, I would still be doing well—and it almost seems like people are trying to upset me by bringing these issues up.”

“How do you mean?”

“Like my therapist, for example, she brought it up, brought the issue of the panty liners up, in our last session and what they are trying to tell me is that I have an obsession with that. I also have obsessive-compulsive disorder, and I went to a hospital for two months to get treatment for that and I’m basically cured of my OCD. Maybe, at times, I might go wash my hands once or twice, if I feel like I need to, but, overall, I feel like the treatment I received there was very good treatment. And, I’ve been successful in overcoming my OCD. They’re trying to make it look like I’m obsessing about these panty liners and that’s why I’ve got to have them and that has nothing to do with it [laughs]. To me, they are the ones who are obsessing about it, because they keep bringing it up.”

It seemed as though staff members had been treating her concerns as merely manifestations of obsessive-compulsive disorder. Not only were they missing the meaning of her concerns, but also they were not listening to her, further isolating Janet from her
environment. “So, you feel like your therapist is saying that it’s not a problem?” I asked.

“My therapist is trying to make it a problem, she was trying to make it a problem” Janet quickly replied.

It seemed as though I had miscommunicated my thoughts to Janet. “Sorry, I didn’t put that very clearly. It seemed like the message she was giving you was to stop worrying about the panty liners and the discharge and stop seeing it as a problem.”

“No, she was telling me that it was a problem and that I need to show the nurse my panty liners, so they can see what’s on them,” said Janet, laughing as she spoke.

“So it gets worse,” I replied.

Janet continued, “That’s why I had to go to the doctor and I know what’s going to end up happening. They are going to come back and they are going to tell me that they don’t think I need to wear them but I, I feel like I need to because I—I mean this is getting a little personal, but it’s just a fact of life, that I feel wet, I feel like there’s some discharge there and I want to wear them just in case I do get some discharge. I want to stay clean.” Again, Janet laughed before she continued, “I’m not obsessing about it. It shouldn’t even be an issue. It’s my social worker’s job to be able to get these things for me, that’s what she’s here for. And, my therapist kept dwelling on the fact that I was obsessing about it and that I need to do this and I need to do that. She got me really upset because that’s all she wanted to talk about.” At this point, Janet became tearful and, before she continued, paused for a moment, “I don’t feel like I’m getting the help that I really need and it’s just now starting to kind of kick in after two months. I didn’t expect for it to start the first day I got here, but within the first week or so I expected to be having some sort of treatment to help me with my anger and my temper tantrums, but I was here almost two months before I started any kind of class or group that focused on my getting help.”

“Do you feel comfortable talking about a time you got angry or had a temper tantrum, and talking about it in detail?” I asked because I wanted to understand how Janet became angry.

“Well, the thing that I do the most is that I cry because I feel like I’m being misunderstood and I get very frustrated. Then my heart starts pounding and I get flushed and then—when I was at the group home, before I came here, the staff would just ignore me and that made it even more frustrating for me. That’s when I would start to hit myself or throw things or hit something ’cause nobody was paying attention to me. I felt like I wasn’t getting any help. That’s kind of the same way I feel here with my therapist…I felt like I was getting better
treatment back home than I am getting here to be perfectly honest. They put me on the waiting list for this hospital and told me that if I started to do better that I wouldn’t have to come. And, I did start to do better—I was gradually getting better. Then, all of a sudden, one morning at 5 o’clock in the morning they wake me up, tell me to get up pack some clothes, and I was on my way here. They didn’t even tell me I was going. I guess they thought I would get upset or something if I knew I was going. But, I didn’t appreciate that. All they did really was throw a bunch of stuff together and drive me up here in a police car. Here, I honestly feel like I’m getting worse instead of better. There are too many things going on that shouldn’t be going on, in my opinion, and I’m not getting the support I feel like I need from the staff. Now, there are some classes that I do get something out of but there are just a few of them. Some of the classes we don’t even have because the teacher doesn’t feel like teaching that day and she just signs our papers.” Janet moved quickly from describing her anger or “temper tantrums.” It appeared difficult for Janet to focus on herself, aside from feeling angry at her environment. While the reasons she cited for being upset were quite legitimate, it seems as though Janet had trouble understanding herself in relation to others.

“That’s upsetting. I get the impression that you are kind of excited to work on some things and start classes.”

“I really want to get better. If I’m going to be here, I want to get better, so I can leave in three months. At the rate I’m going, I’m going to be here another three months. I’m afraid because I’m getting upset, and it’s been over things that should never have happened.” Janet paused for a few moments, as she grew tearful. She continued, “It’s really hard for me right now to focus on my treatment because I am upset over these things. At night, I get really anxious thinking about the next day. I don’t like to be by myself, and, after snack time, it seems like everybody goes to their room or they go to bed. Just a few people stay up, and I get a little anxious before going to bed. And, when I get up in the morning to get ready for the day I feel a little more anxious.”

“What are you worried about?”

“I guess I’m just worried about what the day is going to bring, what I need to do. You know, just the normal things, like getting dressed and getting ready to go. We have to be up and dressed by a certain time. I’m not a morning person. They get us up at 6 o’clock in the morning, and we have to be up and dressed by 6:30. I have a hard time with that, which makes me
nervous. And, just thinking about having to go through another day of God only knows what
[laughs]. I don’t know if I’m going to get upset that day or if I’m going to have a good day or if
I’m going to have a bad day.”

Because it appeared as though Janet was not only afraid of what the next day would
bring, but also her reactions to the events of the day, I offered, “You are unsure about what’s
going to happen, unsure about how you are going to feel and react to things”

“Yeah. And especially now since I haven’t had a very good second month,” she replied.

I wanted to know some more information about Janet’s life and switched topics. “I had a
question that was a little different than where we are now. Do you mind if I step back a bit?” I
asked.

“No,” Janet said.

“You said, it was about 2004 was when your illness started. I guess I’m curious what
exactly you mean by that. Because you mentioned OCD and borderline personality disorder and
I’m curious what you mean by what started in 2004?”

“Well, I started having panic attacks, and then my other symptoms gradually got worse
like my OCD,” Janet quietly answered.

“So that was going on beforehand?”

“That was going on beforehand. It started when I was in my twenties where I would
check things, but it would never be that bad. Once I left the house, I never thought of it again. It
didn’t interfere with my life,” Janet explained.

“So you’d check the stove or the door?” I asked, hoping to understand better.

“Yeah, before I left. And, just out of the blue, I started having panic attacks. And then my
obsessive-compulsive disorder got worse. I started washing my hands and the whole cleanliness
thing, germs and contamination, just really kicked in. I had a real problem with that, and I was
admitted to the hospital several times because of my anxiety and my depression. They tried all
kinds of different medicines on me, of course, and then—I don’t even know that the medicines
I’m on right now are helping me. The medicines that I’m taking for my OCD is helping me
because I’m doing alright in that area of my life, but as far as the anxiety and the depression, I
don’t think my medicine is helping me. Dr. Evert did put me on another medicine that’s actually
for seizures, but he said it can help with anxiety as well. He put me on a big dose and last night
was the first time I really didn’t feel that anxious before I went to bed, but then in the morning I
did. And I’ve spoken to the doctor more than once about how I’ve been feeling, but it seems like he doesn’t care about that as much as he cares about the amount of panty liners that I’m using. Every time he brings me into the office to talk to me it’s about my panty liners. He doesn’t talk to me about anything else, about how I’m doing, or my medication—he doesn’t talk to me about that, he just talks to me about my panty liners.” Again, it appeared as though Janet had difficulty describing her compulsions and quickly moved to the ways she was being mistreated. *Her movement from describing her difficulties with obsessive-compulsive behaviors to the staff’s focus on these behaviors is striking because even though she was concerned about these behaviors, she thought the staff was being unreasonable in their demands. It appeared that Janet felt vulnerable and had difficulty seeing the staff as supportive as well as fallible.*

“Kind of like you’re being ignored?” I asked.

“I am. And I feel like I’m going to be in here forever, for the rest of my life and I don’t want to be. People don’t start paying attention to me, and I tried to tell that to my therapist but she would not listen to me. She just kept going on about the panty liners.” Others seemed to dismiss her perception that they were not paying attention to her, only exacerbating her feelings of being alone and ignored.

“Have you always struggled with anger?” I asked in an attempt to move from the hospital to other times in her life.

“It wasn’t until I got older. I think I inherited it from my dad. My dad’s got an anger problem,” she replied. Her short answers to my attempts to change the topic made me wonder about how she experienced me.

“When did it start?” I asked.

“To be perfectly honest, my anger wasn’t that noticeable until I started having panic attacks in 2004—that’s when everything just started to escalate. Anything that was in my personality just really came out full force. I had struggled with depression before, and my depression came back. I noticed I was crying more and getting upset about things more. My obsessive-compulsive disorder got worse, and my husband just couldn’t take it. On top of that, we had our autistic son to take care of. Now, he’s pretty high functioning, but there’s still problems you’ve got to deal with day to day because their brain doesn’t function the way our brain does. That just added extra stress.” Janet seemed to experience her anger as a part of her “personality,” even if it only manifested later in life. Additionally, I noticed that Janet described
her feelings as symptoms. For instance, instead of describing her sadness, she “noticed that she crying” more often. I wondered if she felt guilty or took an excessive amount of responsibility for the dissolution of their marriage.

“How was your relationship with your husband before he had the affair and you said you were going into the hospital?” I asked, as it was difficult to believe that her relationship deteriorated only because Janet was struggling more.

“We were very distant. I felt like I was doing the majority of things for our son. I was always doing homework with him, always taking care of him, taking him to school, picking him up from school. I felt like I was the primary caretaker of our son. My husband could just sit in the lazy boy chair and watch T.V. Granted, it’s not that he just didn’t do anything, but he just wouldn’t talk about things. And, I know he had to have been having an affair probably even before I started having these problems because we were having communication problems before that. And, I felt like I was being mistreated sexually in the relationship, too. Thus, there ended up being no physical relationship.

“Was he abusive or was he—can you say more about that?” I asked.

“Well, in the relationship I had before him, I was raped. I had some issues with having sex when we first got married. It wasn’t bad, but as time went on, we had our son and we had to deal with other things, you know? It got less and less, and he was wanting it all the time.” Janet paused and fought back tears. “And even—he asked me—I was in pretty bad shape by the time he asked me for the divorce—and even then he would ask me to have sex with him.”

“After he asked you for a divorce?” I asked a bit surprised. I realized that I began to take on Janet’s anger and frustration as my own. As it was difficult for Janet to express her anger directly, I found myself being angry for her, as her stories of being mistreated were difficult to hear.

“Yeah, I don’t want to start crying or anything. I really don’t, but I just feel like I’ve been abused my whole life, and nobody is helping me, nobody is helping me [Janet is sobbing at this point] nobody’s helping me. They are only making things worse, and that’s why I’m here, because I just kept getting worse and worse and nobody’s helping me,” Janet responded.

I reflected, “It sounds like you have very few people that supported you in your life.”

“My parents don’t call here, but they are supporting me. I mean I call them and talk to them on the phone, but they don’t call here and see how I’m doing. My older sister, the one who
supported me the most, she died last year of an aneurism, so I don’t have her to talk to. I just don’t know what to do. That’s why I’ve been spending a lot of nights crying while I’m here. But, I don’t get any support here either—I’m supposed to get over it, I’m supposed to just deal with it. The only classes that I’m taking that I feel like are going to help me are the anger management and the DBT classes that I’m taking. They’ve got me taking a health and beauty class where we paint our fingernails and put on makeup. How’s that going to help me, really? That’s not the kind of help I want. Half the time we don’t even have the class. There are classes I’m supposed to be taking and there are some of them that I feel would be beneficial for me, but we end up in the social area or we end up in the library, not having the class. Or, somebody doesn’t feel good or they are in a bad mood and don’t feel like teaching a class that day, so they don’t teach it—that’s the self esteem class which I really need too.”

“When you say you need some support what would that look like for you?” I asked.

Janet paused for a few moments and reflected upon my question. She responded, “Well, I would like to be able to take my classes and be serious about it. That will help me better understand why I’m having this anger and why I’m getting so upset—it will help me to deal with it better. I also want to get rid of this anxiety I have. I still have a lot of anxiety; I have anxiety over taking a shower. For some people, it is relaxing to take a shower, but, to me, it is an ordeal to have to get everything ready to take a shower—and then get dressed. This all causes me anxiety. I just feel, like I said, like I’m getting worse instead of better. And, maybe now that some of these other classes have kicked in I’ll start to do better. But, I’ve gotten to the point to where I don’t know if I’m going to be able to fully concentrate on these classes because of the way I feel—because I’m very upset. I know I’ve had a bad month, and my gatekeeper is probably going to be coming soon. He’s probably gonna make me stay longer than the three months because of these issues that have come up that to me have no importance whatsoever and have nothing to do with my treatment. My therapist seems to think that it has to do with my treatment cause I’ve got OCD, but my OCD is the only thing that I’ve got under control. I need help with everything else. And I’m not getting that help.” It seemed that Janet equated support with having classes and understanding her emotions better. It seemed difficult for her to say that she needed others to see things from her perspective or that she needed others to empathize with her more and, instead, she described the role of psychoeducational classes in her treatment.

I wanted to know more about the role of others and said, “You said before that you
thought you could call your parents, but they don’t really call you.”

“Yes.”

I waited for more of a response, but Janet did not offer one. I asked, “Is that something that has always gone on?”

“Yes. And I think it’s because they think they don’t want to bother me,” she replied quickly.

“Did that go on as a child too?” I asked, hoping that she would elaborate.

“Yes,” she responded.

“How would that look?” I asked, but Janet did not hear me. “How would that look, were they just not really there when you needed them?” I said again, elaborating a bit more.

“Well, I feel like they are there, but, yet they are not, because they don’t call me. It was the kind of relationship to where if you did have a problem, you weren’t sure if you were going to be able to talk to them about it because of my dad’s temper for one thing and because she would get upset, maybe, over what it is I needed to talk about,” she responded. It seemed as if Janet rarely had emotional support and her difficulty in answering my questions regarding support made more sense. It appeared as though Janet’s attempts to ask for support were often dismissed and invalidated by her parents’ emotions.

“So, if you had something upsetting to talk about she would get upset, that you were upset and couldn’t hear it.” I reflected.

“Yeah,” she responded.

“It seems like you were afraid around your dad a lot.” I said.

“Yes,” she said again.

“You worried that if you did something wrong, it would bring out his temper?” I asked, worried that Janet could not elaborate on her father’s anger.

“Yes. And sometimes his temper would come out, and I would get scared.”

“What sort of things would you do to make him upset?” I asked.

“I don’t even know, I couldn’t even tell you what those things were. Something somebody might have said, or something that might have even happened to him that got him upset and he’s taking it out on us. I remember one time my dad abusing me. He picked me up by the shoulders and slammed me against the wall. Then, he carried me by my shoulders in to the bedroom and threw me on the bed. I don’t even know what it was for—I couldn’t tell what it
even was about or if it even had to do with me.”

“Where was your mom when all this was going on?” I asked.

“She was right in the middle of it too—crying. My dad would make my mom cry a lot.”

“He was abusive to her too.” I said.

“Yes. My older sister, she was about five and a half years older than I, so she remembers things that I don’t. She told me that my dad used to bang my mom’s head against the concrete wall in the basement and he would abuse her. My mom would call for help and have her come downstairs so he would stop.”

“He wouldn’t abuse your Mom in front of her?” I asked.

“No,” Jane said tearfully.

“So, it was like you knew what was going on but never really saw it.” I reflected.

“Sometimes.”

“That would be really hard to see as a child.”

Janet confirmed that it was hard and paused for a few moments reflecting on our conversation. After a few moments, I asked, “Before you said you are afraid to be alone. Have you always felt this way?”

Janet paused for a few moments and said, “It’s more now than anything. I think when we were married for 14 years—I guess I just got used to having somebody there all the time and doing certain things. And when we got divorced, I had to relearn how to do certain things on my own. I had to take care of the bills and everything else that my husband took care of when we were married. It seemed like the nighttime was the worst for me being by my self.”

“Were you living alone?”

“I was living alone. To tell you the truth, I just felt alone in my life. It wasn’t just that I was by myself in an apartment. It was like I didn’t have anybody. I really didn’t have my parents, you know, and all my friends were back where I lived when I was married. When we got divorced, I moved back home, with my mom and dad, for a while and then I got an apartment near my parents’ house, so all my friends and my close friends were about thirty minutes away. So, I didn’t really have any friends, and I was alone in both ways.”

“It sounds when you were married even though your husband was there, was there in the house, you still felt very alone?” I asked, thinking that this sense of aloneness permeated Janet’s life.
“I would feel alone at times, but even just the presence of somebody being there helped. And, I have my son to take care of, and I just feel like all that was taken away from me.”

“Even as things got worse with your husband?”

“Just my son.”

“You tried to keep things together for him?” I asked.

“Yes.”

“Do you think he was hard on him too? How was his relationship with his father?”

“It was ok,” Janet tersely replied.

“Even though you were spending more time with your son?” I asked, as there seemed to more to this description.

“My husband would take my son up to his mom and dad’s house in the evenings, sometimes, to spend some time with them. He bought a four wheeler, and he took him for four wheeler rides, but other than that, he wouldn’t really spend that much time with me so—with our son. He would just basically do the same thing. Take him up to his mom and dad’s and sit on the couch with his laptop computer or watch TV or something, while my son was off playing by himself.”

“Looks like he could have done that at home.”

“Yeah,” Janet paused before she could continue, “What I want more than anything right now is for somebody to help me get the treatment that I need to get better.” It seemed as though Janet desperately wanted to “get better” so she could be back with her son.

“I can see you are really excited to figure some things out,” but in my attempts to provide some comfort, I had cut Janet off. “Where you going to say something else?”

“I was just going to say that I’ve got this worry, I worry a lot too. I have this constant worry in the back of my mind that I’m going to have to stay three months longer or something. And, I don’t really want to. As a matter of fact, I don’t want to even be here. I want to go home, like I said, I feel like I was getting better treatment at home than I’m getting here,” Janet said angrily. I silently wondered if her concerns were not being taken seriously by the staff by understanding her concerns as part of her pathology.

“What was treatment like at home?”

“We would have classes as well, in groups. But you actually did something in the group, you participated, and you got something out of it. According to how you participated that would
determine how long you would spend at the treatment program. At the end of the day, one of the staff members would go over what you did that day and they would, how do you say it, monitor your progress in different areas that you needed help in, see how you are doing. At the same time, you saw a therapist and a psychiatrist to help each patient and it was all there in the same place,” Janet explained.

“What sorts of things would you talk about with your therapist, if you don’t mind me asking?” I asked.

“Well, we were supposed to have at least a half hour session, and it ended up being 20 minutes, if that at all. Sometimes we would talk about things that were going on, you know, our progress, how we were doing. As a matter of fact, before I came here, we were even talking about my getting a part time job and getting my own apartment again, which is why I wonder why I’m here if that’s what we were talking about.”

“Yeah, that’s strange. So you don’t really know why they decided to bring you here as opposed to staying there. It sounds like your therapist thought you were doing better?”

Janet replied, “I was doing my best to try and do better—have fewer temper tantrums and to use my coping skills to deal with different things. And, I thought I was doing better, but apparently, they thought I wasn’t doing better enough. So, they sent me up here and now I feel like I’m getting worse. I don’t feel like I’m getting better, my first month here, I thought I was, but the second month not so much. Like I said, they are focusing on things that don’t even have to do with my treatment and that’s very upsetting to me. It makes it hard for me to concentrate and really take advantage of the treatment I am getting now ‘cause I know I’ve had some bad days and that’s going to affect the amount of time I spend here.”

“The things you say make me think that there are so many things that have happened in your life that would make anybody angry. I’m wondering if you felt angry at the times these things happened.”

“Probably once I got out on my own, after I graduated from college, when I felt like I had some control over my life, when before I didn’t. I know my anger came out with my parents a few times after I graduated college when I got the job to teach piano lessons. I only started out with eleven students. My mom got all upset because, here I went to college for four years, and I’m not teaching in a school anymore and I’m going to be teaching piano lessons and I only have 11 students and she thought that was a waste of their money and time and everything—sending
me to college and I got upset with my mom.”

“Sounds like you were happy giving piano lessons,” I offered.

“Yeah and it wasn’t long before I ended up with 40 students and then I ended up as education director.”

“You have to start somewhere. So, you really wouldn’t say that you were angry at your parents before that?” I asked in an attempt to understand Janet’s anger better.

“I was more scared of my dad when I was growing up and there was a fear there.”

“It seems like you couldn’t really express yourself. You couldn’t really express anger because you were afraid—you didn’t know what was going to upset him so you couldn’t really—it’s almost like you felt like you had to be invisible on some level.”

“Yeah.”

“Kind of fly under the radar,” I reiterated, but Janet did not respond. I was not sure if this was accurate but difficult to accept or did not fit her understanding of herself. After a few moments, I asked how she spent her time.

“In my room.”

“Alone?”

“Yes. I was in band when I was in school so that kept me busy, that got me out, and I had some friends in that,” Janet responded.

“Did you have a lot of friends growing up, or was it just friends from band or did you spend most of your time alone too?”

“It was mostly friends from band ‘cause we spent a lot of time together rehearsing and that sort of thing. And, then, I had some other friends that were in my class as well, but not very many. I wasn’t part of the popular crowd because I was in band [laughs]. It was a sports oriented school.”

“High school was pretty rough then?”

“Yes. My mom was the one who expected me to get straight A’s and I didn’t live up to that either.”

“You felt a lot of expectations from her?”

“Yeah, now my last two years in high school, I ended up on the honor role. I got A’s and B’s,” Janet explained. “Before that, on the very first report card, I got an A, like two B’s and two C’s maybe. And, my mom had a fit—that wasn’t good enough and from that point on, I
went down hill. My grades got worse, and I was happy with my report card, but she wasn’t. It wasn’t until my junior year in high school that I finally got it together and made good grades.”

“They didn’t seem that bad to begin with.”

“But my mom thought it was. My mom was valedictorian of her class and my sister was in the top ten of her class, so I was expected to live up to those expectations.”

“It doesn’t seem fair to be held up to someone else’s expectations.”

“No,” Janet responded, but did not elaborate. After a few moments, I asked, “When you say ‘you inherited’ what do you mean by that?”

“Well, I guess I witnessed it and there are the genes that I inherited from him, that disposition in there.”

“There’s something biological about it then?” I asked.

“Yeah,” Janet replied but, again, did not elaborate.

“You said witnessing it. How do you think witnessing it has affected you?” I asked.

“Probably. I witnessed my dad and what he did when he got angry and, so, then that’s what I did ‘cause that’s the only way I knew how to express my anger.”

At this point, we decided to end our conversation, as Janet only had a few minutes to go to a music class. I asked her how she felt about our conversation and she said, “It made me a little upset, but it’s good to get this stuff out.”

Preparation of the Experiential Constructivist Diagnosis. In this section, I will be providing the diagnosis I presented to Janet juxtaposed with a description of how the diagnosis group constructed the EPCP diagnosis. Throughout the diagnosis, the research group gave Janet some examples that provided a basis for our decisions about her experiential constructivist diagnosis. However, the research group used many more examples of her struggles than we could provide in a summary. On axis I, we decided that Janet struggled with maintaining permanence when distressed. During periods of relatively low levels of distress, Janet appeared to have a fairly solid sense of self-other permanence. We inferred that she may have even had some sense of self-other constancy during times of low distress. Because her struggle to maintain self-other permanence was the most salient issue, we structured much of the diagnosis around permanence. On axis II, we concluded that Janet overdispersed her dependencies. Finally, on axis III, we decided that Janet struggled most with discrimination, openness, commitment, forgiveness and responsibility. We did not discuss flexibility, creativity, courage
and reverence in the narrative of her diagnosis.

The research team thought Janet struggled primarily on axis I, specifically with maintaining self-other permanence. Thus, we began her diagnosis describing her struggles with permanence and the impact of structural arrests:

The intense struggles you have been experiencing may be understood in relation to the injuries you experienced at an early age. These injuries make it difficult to maintain a solid and stable sense of self—a self that you could use to engage others and the world. For all of us, early understandings of the self are fragile and tenuous. However, with reliable and consistent nurturing, these understandings become more solid and stable. Unfortunately, the people closest to you often acted in unpredictable ways, making it difficult for you to develop a more stable sense of self. For example, at times, it seems as though you see yourself as accepting and caring. At these times, it seems that you also see others as accepting and caring, which allows you to be more flexible with them. At other times, it seems as though you understand yourself as angry and are less accepting of your emotions and actions. At these times, you may fear others, as they seem dangerous and hurtful. Integrating these two sides of yourself may be a struggle, but may allow you to feel more solid and stable.

In this part of the diagnosis, we wanted to capture Janet’s fundamental struggle, maintaining awareness of the disparate parts of her self. At times, the narrative sounds like a description of self-other constancy in that it seems as Janet vacillates between different ways of being. However, the diagnosis group believed Janet lost awareness of parts of herself instead of having trouble integrating these disparate parts. Thus, her diagnosis was focused on permanence struggles. For example, when Janet became angry, it appeared as though she became her anger as opposed to felt her anger (Kegan, 1982). While angry, she lost touch with her constructions of herself and others as caring people. She became nothing but anger. Because Janet had difficulty feeling solid in her construction of self and other when angry or distressed, we decided to describe her struggles in terms of self-other permanence.

We continued by using an example that Janet provided. The aforementioned frustration and confusion mirrored how she described her father:

As mentioned above, the unpredictable actions of those closest to you make it difficult to integrate these two aspects of yourself in order to feel solid. One example of this struggle
is the way you describe your father. It seems like it was difficult for you to predict his moods and his reactions to his environment. This was especially difficult as he often had angry and violent reactions to others, which were frightening to you. This was made even more difficult, as it seems as though it was not a response to something you had done. When children exist in unpredictable environments, they tend to believe that they were the cause of a violent outburst by a caregiver. It seems like no matter what you were doing, you feared your father’s reaction to you. In other words, it seems as though you were always worried about punishment from him. You mentioned staying in your room a lot, which makes sense when living in this type of environment. This would make it difficult to accept your own emotions, including anger, as the emotions of your father were often destructive.

While his abusive acts seemed to be directed at your mother, you often saw or heard the violence that would occur. The fear that accompanies these experiences, especially as his anger seemed to come out of nowhere, seems to have affected your ability to trust your emotions and feelings. Childhood feelings of sadness or anger (that were legitimate) needed to be hidden, as there was the chance of your father becoming angry. The worry and anxiety that you describe seems to have affected you greatly and may be understood in relation to your experience of your father during childhood and adolescence. It seems as though you had to worry about his reactions and behavior. It seemed as though it was very difficult to stay calm when you could not predict how safe your environment would be. These feelings of worry may have been exacerbated by your mother’s criticisms and judgments of you.

Because it appeared as though Janet had a sense of inner chaos and unpredictability, we wanted to provide a context for how such feelings may have developed. Put differently, we wanted to make the implications of not having a stable and consistent environment clear in terms of constructing and maintaining a solid sense of self.

We continued by describing how these struggles with self-other permanence manifested themselves in her present life:

These struggles seem to affect you currently. For instance, when life is relatively stable and is not causing much stress, you are able to maintain a stable sense of self that allows you to relate to others and the world. When you become stressed, however, it seems
difficult for you to maintain a stable sense of self. In other words, you seem to shift from being accepting and trusting to being more mistrustful and angry. This may affect your ability to engage with others, as interactions with others during these times often leave you feeling hurt. During times of low stress, these injuries may still feel painful, but may not affect your overall stability. Oftentimes, such inconsistencies feel confusing and painful, as did the inconsistencies in your father’s behavior. This may allow you to understand your anger better, as it seems as though you feel left with few alternatives when others hurt you.

The research group believed that our description captured the ways Janet’s structural arrest was manifested in her present experience. In addition, we described some of Janet’s strengths in that she could meaningfully relate to others and care for them when she felt permanent and constant.

We moved to describing how struggles with self-other permanence manifested themselves in relation to her difficulty entering into relationships:

Because you were not able to reliably depend upon your parents’ moods and behaviors, it seems difficult for you to negotiate when to trust and depend on others. During times of stress, it seems as though you feel hurt, pull away from others and distance yourself from others. When you are not upset, you find it easier to engage and open up with others. At these times, it seems as though you can trust most people, possibly many others. This seems dangerous, as trusting too many people leaves us open to getting hurt. Trusting others allows us to be open to others and feel supported and validated, but not everyone can support us in the ways that feel correct for us.

To explain how Janet overdispersed her dependencies, we connected her struggles with self-other permanence to her difficulty trusting others and choosing relational partners.

We tried to connect Janet’s troubles with dispersing her dependencies to her struggles with discrimination:

Managing this tension seems difficult. All relationships have the potential to injure us. Discriminating between those where the risk of injury is too high versus those where the risk feels more acceptable can be a struggle. At times, you may find yourself allowing others to become close to you—people that have the potential to invalidate and hurt you. When this occurs, it is hurtful and you may not allow others that could be supportive into your life.
Discrimination seemed crucial for Janet, as she often allowed people (usually men) who had the potential to injure her both physically and psychologically to become close to her.

We moved to describing her troubles with openness, as they appeared to be connected to her struggles with discrimination:

It seems as though there have been times when others have made mistakes and have hurt you, but you have been able to accept those parts of you and the other person that are still loving and supportive. At other times, it seems as though the injuries of others were too great and did not allow you to feel the parts of them that were supportive and loving. At these times, most others may seem dangerous. Additionally, others may seem as though they do not understand you and may make you feel alone. Feelings of anger and the urge to hit yourself may appear at these times.

We then moved to describing her struggles with commitment and forgiveness:

Negotiating this tension seems difficult, as you have trouble leaving relationships that have been difficult or unsupportive. Your ex-husband seemed unsupportive and may have hurt you, but also it seemed difficult to leave him. You describe feeling anxious when alone and your husband’s presence may have alleviated these feelings. However, enduring the pain in this relationship may have been too much to bear. Towards the end of this relationship, you describe struggling more, feeling more depressed and upset, worrying more and getting angry more intensely and often. While this relationship may have been painful, it gave you some stability. As this relationship ended, however, you were left with emotions that were difficult to understand. Understanding how you were hurt in this relationship in relation to the other psychological injuries in your life (your father’s violence, your mother’s inability to help you, mistreatment by other men), may assist in feeling more in control of your emotions. When psychological injuries occur in past relationships, it becomes difficult to leave these injuries in the past. Understanding new relationships in terms of old relationships is useful, but we often can bring the hurt from past relationships into our current ones.

We ended her diagnosis with a discussion of responsibility. While Janet seemed to struggle with taking too much responsibility at certain times and take too little at other times, we focused on the former, as it seemed closer to her frame of reference:
Furthermore, it seems as though you become upset or angry with yourself when relationships are not going well. Taking responsibility is important, but taking too much responsibility can leave us hurt and feeling unfulfilled. Understanding how your emotions affect your understandings of yourself and your relationships with others may be important. As with all of life there is a tension here between being overly responsible for things versus blaming others excessively.

The goal of this last paragraph was to stress the importance of realizing where responsibility began and ended and provide some ways for Janet to utilize this in her life.

While I have provided the entire description of the diagnosis that I presented to Janet, I will provide the unbroken description to facilitate comparison of the two diagnoses for the reader. I provided the following description to Janet:

The intense struggles you have been experiencing may be understood in relation to the injuries you experienced at an early age. These injuries make it difficult to maintain a solid and stable sense of self—a self that you could use to engage others and the world. For all of us, early understandings of the self are fragile and tenuous. However, with reliable and consistent nurturing, these understandings become more solid and stable. Unfortunately, the people closest to you often acted in unpredictable ways, making it difficult for you to develop a more stable sense of self. For example, at times, it seems as though you see yourself as accepting and caring. At these times, it seems that you also see others as accepting and caring, which allows you to be more flexible with them. At other times, it seems as though you understand yourself as angry and are less accepting of your emotions and actions. At these times, you may fear others, as they seem dangerous and hurtful. Integrating these two sides of yourself may be a struggle, but may allow you to feel more solid and stable.

As mentioned above, the unpredictable actions of those closest to you make it difficult to integrate these two aspects of yourself in order to feel solid. One example of this struggle is the way you describe your father. It seems like it was difficult for you to predict his moods and his reactions to his environment. This was especially difficult as he often had angry and violent reactions to others, which were frightening to you. This was made even more difficult, as it seems as though it was not a response to something you had done. When children exist in unpredictable environments, they tend to believe that
they were the cause of a violent outburst by a caregiver. It seems like no matter what you were doing, you feared your father’s reaction to you. In other words, it seems as though you were always worried about punishment from him. You mentioned staying in your room a lot, which makes sense when living in this type of environment. This would make it difficult to accept your own emotions, including anger, as the emotions of your father were often destructive.

While his abusive acts seemed to be directed at your mother, you often saw or heard the violence that would occur. The fear that accompanies these experiences, especially as his anger seemed to come out of nowhere, seems to have affected your ability to trust your emotions and feelings. Childhood feelings of sadness or anger (that were legitimate) needed to be hidden, as there was the chance of your father becoming angry. The worry and anxiety that you describe seems to have affected you greatly and may be understood in relation to your experience of your father during childhood and adolescence. It seems as though you had to worry about his reactions and behavior. It seemed as though it was very difficult to stay calm when you could not predict how safe your environment would be. These feelings of worry may have been exacerbated by your mother’s criticisms and judgments of you.

These struggles seem to affect you currently. For instance, when life is relatively stable and is not causing much stress, you are able to maintain a stable sense of self that allows you to relate to others and the world. When you become stressed, however, it seems difficult for you to maintain a stable sense of self. In other words, you seem to shift from being accepting and trusting to being more mistrustful and angry. This may affect your ability to engage with others, as interactions with others during these times often leave you feeling hurt. During times of low stress, these injuries may still feel painful, but may not affect your overall stability. Oftentimes, such inconsistencies feel confusing and painful, as did the inconsistencies in your father’s behavior. This may allow you to understand your anger better, as it seems as though you feel left with few alternatives when others hurt you.

Because you were not able to reliably depend upon your parents’ moods and behaviors, it seems difficult for you to negotiate when to trust and depend on others. During times of stress, it seems as though you feel hurt, pull away from others and
distance yourself from others. When you are not upset, you find it easier to engage and open up with others. At these times, it seems as though you can trust most people, possibly many others. This seems dangerous, as trusting too many people leaves us open to getting hurt. Trusting others allows us to be open to others and feel supported and validated, but not everyone can support us in the ways that feel correct for us.

Managing this tension seems difficult. All relationships have the potential to injure us. Discriminating between those where the risk of injury is too high versus those where the risk feels more acceptable can be a struggle. At times, you may find yourself allowing others to become close to you—people that have the potential to invalidate and hurt you. When this occurs, it is hurtful and you may not allow others that could be supportive into your life.

It seems as though there have been times when others have made mistakes and have hurt you, but you have been able to accept those parts of you and the other person that are still loving and supportive. At other times, it seems as though the injuries of others were too great and did not allow you to feel the parts of them that were supportive and loving. At these times, most others may seem dangerous. Additionally, others may seem as though they do not understand you and may make you feel alone. Feelings of anger and the urge to hit yourself may appear at these times.

Negotiating this tension seems difficult, as you have trouble leaving relationships that have been difficult or unsupportive. Your ex-husband seemed unsupportive and may have hurt you, but also it seemed difficult to leave him. You describe feeling anxious when alone and your husband’s presence may have alleviated these feelings. However, enduring the pain in this relationship may have been too much to bear. Towards the end of this relationship, you describe struggling more, feeling more depressed and upset, worrying more and getting angry more intensely and often. While this relationship may have been painful, it gave you some stability. As this relationship ended, however, you were left with emotions that were difficult to understand. Understanding how you were hurt in this relationship in relation to the other psychological injuries in your life (your father’s violence, your mother’s inability to help you, mistreatment by other men), may assist in feeling more in control of your emotions. When psychological injuries occur in past relationships, it becomes difficult to leave these injuries in the past. Understanding
new relationships in terms of old relationships is useful, but we often can bring the hurt from past relationships into our current ones.

Furthermore, it seems as though you become upset or angry with yourself when relationships are not going well. Taking responsibility is important, but taking too much responsibility can leave us hurt and feeling unfulfilled. Understanding how your emotions affect your understandings of yourself and your relationships with others may be important. As with all of life there is a tension here between being overly responsible for things versus blaming others excessively.

Validation of the DSM Diagnosis. Janet was diagnosed with Borderline Personality Disorder. Because Janet reported that she received successful treatment for obsessive-compulsive disorder, the hospital focused its treatment plan around the borderline personality disorder diagnosis. The research group used much of the language of the DSM and did not change very much, other than explaining some of the language. I will describe how Janet met criteria for borderline personality disorder and provide the description I presented to Janet.

One must meet five of the following criteria to be diagnosed with Borderline Personality disorder (the ones we think she met are in bold): (1) frantic efforts to avoid real or imagined abandonment; (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; (3) identity disturbance: markedly and persistently unstable self-image or sense of self; (4) impulsivity in at least two areas that are self-damaging; (5) recurrent suicidal behavior, gestures or threats or self-mutilating behavior; (6) affective instability due to a marked reactivity of mood; (7) chronic feelings of emptiness; (8) inappropriate, intense anger or difficulty controlling anger; (9) transient stress related paranoia or severe dissociative symptoms. From our diagnostic interview, it appeared that Janet met these five criteria.

We presented the following description of borderline personality disorder to Janet:

Individuals with struggles similar to yours are characterized in the following fashion. The essential feature of such struggles is a pervasive pattern of instability of interpersonal relationships, self-image, and affects (emotions), and marked impulsivity that begins in early adulthood and is present in a variety of contexts.

Individuals with such struggles make frantic efforts to avoid real or imagined abandonment. The perception of impending separation or rejection, or the loss of external
structure, can lead to profound changes in self-image, affect, cognition and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician’s announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this “abandonment” implies that they are “bad.” The abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors.

Individuals with such struggles have a pattern of unstable and intense relationships. They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, is not “there” enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will “be there” in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their views of others, who may alternatively be seen as beneficent supports or cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self. There are sudden and dramatic shifts in self-image, characterized by shifting goals, values and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with such struggles may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing and support. These individuals may show worse performance in unstructured work or school situations.
Individuals with such struggles display impulsivity in at least two areas that are potentially self-damaging. They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly. Individuals with such struggles display recurrent suicidal behavior, gestures or threats or self-mutilating behavior. Completed suicide occurs in 8%-10% of such individuals, and self-mutilative acts (e.g., cutting, burning, hurting oneself physically) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that they assume increased responsibility. Self-mutilation may occur during experiences where the person feels separate from himself or herself and often brings relief by reaffirming the ability to feel or by expiating the individual’s sense of being evil.

Individuals with such struggles may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than few days). The basic dysphoric mood of such individuals is often disrupted by periods of anger, panic or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual’s extreme reactivity to interpersonal stresses. Such individuals may be troubled with chronic feelings of emptiness. Easily bored, they may constantly seek something to do. Such individuals frequently express inappropriate, intense anger or have difficulty controlling their anger. They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil. During periods of extreme stress, transient paranoia, feelings of being separate from oneself or not feeling real may occur. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver’s nurturance may result in a remission of symptoms.

Individuals with such struggles may have a pattern of undermining themselves at the moment a goal is about to be realized (e.g., dropping out of school just before graduation; regressing severely after a discussion of how well therapy is going;
destroying a good relationship just when it is clear that the relationship could last). Some individuals develop other symptoms (e.g., hallucinations, distortions of body image) during times of stress. Individuals with this disorder may feel more secure with transitional objects (i.e., pet or inanimate possession) than in interpersonal relationships. Premature death from suicide may occur in individuals with this disorder. Physical handicaps may result from self-inflicted abuse behaviors or failed suicide attempts. Recurrent job losses, interrupted education, and broken marriages are common. Physical and sexual abuse, neglect, hostile conflict and early parental loss or separation are more common the childhood histories of individuals with such struggles.

There is considerable variability in the course of these struggles. The most common pattern is one of chronic instability in early adulthood, with episodes of serious affective and impulsive dyscontrol and high levels of use of health and mental health resources. The impairment from these struggles and the risk of suicide are greatest in the young-adult years and gradually wane with advancing age. Although the tendency toward intense emotions, impulsivity and intensity in relationships is often lifelong, individuals who engage in therapeutic intervention often show improvement beginning sometime during the first year. During their 30s and 40s, the majority of individuals with these struggles attain greater stability in their relationships and vocational functioning. Follow-up studies of individuals identified through outpatient mental health clinics indicate that after about 10 years, as many as half of the individuals no longer have a pattern of behavior as severe as when the struggles began.

It is five times more likely that someone with such struggles is directly related to someone with similar struggles.

Presentation of the DSM Diagnosis. Two weeks after the initial interview, Janet and I met for the research interview. Upon arriving for the interview, Janet described that she was struggling more in the last few days. She described how the symptoms of “her OCD” were worse during times of stress. While she looked distressed, she displayed some optimism and described how she saw each day as a chance to start again.

Before presenting Janet with her DSM diagnosis, I asked her about her personal theory of psychological struggles. After joking that it was a difficult question, she said, “Well, since I’ve been here I haven’t really—I’ve talked to a therapist a few times, but I never really sat down and
really talked about what it is I'm diagnosed with and different ways to help with it. I almost feel like I was just thrown into this place, and there are maybe a few—I can count on one hand the classes that really help me in any sort of way. Like my DBT classes are supposed to, are specifically designed to help people with borderline personality disorder and then I'm taking classes like art classes, paper making and things like that, that I don't think are going to benefit me in the long run as far as what problems I'm having.” Janet had trouble answering my question and it seemed difficult for her to discuss psychological struggles abstractly. Janet continued, “I have a problem with this place and no one, like I said, has really sat down with me and talked to me like this, like what we are doing. I’ve talked to my therapist maybe three times since I’ve been here and I’ve been here almost three months.” Janet paused for a few moments, as she grew tearful. “I feel like I’m being cheated out of something, cheated out of the good treatment that I’m supposed to be receiving. My therapist back home said that this is such a good place and how I would be a totally different person when I got out of here. I do feel like a different person right now than when I came in—but it’s not for the better, it’s for the worse. That really upsets me. ‘Cause why is my OCD getting worse? Why am I feeling this extra stress and extra pressure? I’m told that this stress is bringing on this onset of my OCD because it is an anxiety disorder. And, last year, I attended two months in a treatment program to treat my OCD and it practically cured me of it and now I feel like I’m almost having to relearn those techniques that I learned there because my OCD is getting worse again.”

I had difficulty hearing Janet’s words, as she felt helpless, afraid, and changed by the hospital. Janet entered the hospital (and the research project) with a medicalized understanding of her struggles. The hospital, however, seemed to strengthen this belief. Her mistrust of the environment was translated into stress and her obsessive-compulsive behaviors arose because of stress (e.g., diathesis-stress model of psychopathology). Thus, it seemed she felt confused by her emotions.

Janet continued to express feelings of uncertainty and helplessness: “Now I know that they say that they have seen improvement in me, they have written good things about me, I’ve only had one outburst since I’ve been here, but I don’t know that I’m actually going to really—once they do discharge me, am I going to be better? Will this experience have been as good for me as what everybody said it was going to be?”

“Right now it doesn’t seem—” I reflected.
“It doesn’t seem that way at all to me and, um, right now I’m very discouraged I really
don’t feel like anybody really wants to help me. Like I said, there’s my DBT classes and I feel
like I’m getting something out of those, but the rest of my classes really aren’t helping me in the
way that I feel like they should be helping me.”

“Do you find your work with your individual therapist helpful?” I asked, trying to
understand what good, effective treatment would look like for Janet.

“Yeah. And she’s giving me these diary worksheets to keep track of how my days have
gone and what kind of DBT skills I use during the day, which has been helpful.”

“If it was up to you what would you want your treatment to look like?” I asked directly.

Janet explained, “I would like to meet with somebody individually everyday. I do have
the DBT classes four times a week, which is good. The other classes, like the anger management
class, help as well because I have a problem with anger. I just I wish more time was spent on
what I needed. I wish I had those specific classes, even if it was just two or three of them, I wish
I had those everyday of the week and that I would be seeing a therapist or somebody like that
every day of the week and just really focus in on what my diagnosis is and to help me get past
that so I can live a better life. I go to a health and beauty class where we paint our nails every
time we go. What the hell is that going to do to help me? It makes me want to scream. I really
don’t give a shit about getting my nails painted once a week; I want to get better so I can get out
of here.”

Janet and I spent the next few minutes discussing how she felt mistreated and uninformed
about her treatment. Essentially, it appeared that Janet felt alone, mistreated by the staff on an
institutional level (e.g., having trouble meeting with someone to discuss her treatment plan) and
an interpersonal level (e.g., being ignored or made fun of). While Janet had difficulty answering
my questions and abstracting from her experience, I thought that she felt that others were mostly
responsible for psychopathology and treatment. I then invited Janet to read the DSM diagnosis
and asked if she had any questions or initial impressions.

“No. There were some things I could relate to, especially at the beginning,” Janet said
before pausing for a few moments.

“What sorts of thoughts did you relate to?” I asked.

“When they were talking about the abandonment,” she replied. Again, she paused.

“You find yourself feeling that way?” I asked.
“Yes.” Janet paused for a few minutes and looked over the diagnosis again. “You listed, some things that didn’t fit like the displaying impulsivity, and the two areas that potential self-damaging. I’ve never done any of these things that you listed, but when it did seem like nobody was caring nobody was helping me that I would make suicidal threats. A lot of times I didn’t really mean it, but I felt so bad that I didn’t want to be there—and it always seemed like people ignored me when I did that.”

“You made threats to kill yourself because they were ignoring you.” I reflected.

“When I was in my group home and I would get upset over something—like say a phone call or something—they were too busy to listen to me. That only aggravated the situation and made me more frustrated and more upset, so that’s when the temper tantrums would start and, of course, those would get ignored,” Janet explained.

“Why do you think they were ignored?” I asked.

“That’s what they told them to do, they said. And that’s pretty much what they do here.”

“So if someone is struggling and sad, they are told to ignore it,” I said and paused to allow Janet to reply. When she did not, I asked, “Is it like that with everybody?”

“With most people. There was somebody last night who did take the time out to talk to me about my OCD problem.”

“It felt good to talk about it?”

“Yeah.”

“How do you feel when you are ignored?”

“I feel like nobody cares. And the excuse I’m given is, ‘We’ve got thirty other patients that need to be taken care of.’ But, I’m one of those thirty other patients is the way I look at it, and I need help right now. It seems like they are always busy with paper work or something else they have to do and they don’t take the time out to talk to you and, if they do, it’s with a hmmmph [makes exasperated sound] attitude,” Janet softly replied.

“Seems like that’s not very helpful.”

“No. Like they really don’t want to do it. I probably sound like all I do is complain all the time.”

“To me?”

“Yeah.”
“I’m not sure that I would say that. You say that you struggle with anxiety and struggle with being angry and have a temper. It seems like that would be the best times for people to talk to you.”

“The staff is too busy to do that. They have time to joke around with somebody who bangs his head on the glass and starts fights, they have time to sit there and joke around with somebody like that,” Janet said in a soft but angry voice.

“What else do you relate to?” I asked but Janet seemed to not know how to respond.

“Before you were saying that you don’t really do some of the impulsive things that are listed there like gambling is on there, things like that some people do.”

“Spend money.”

“You seemed to say the suicidal thoughts and actions were impulsive at times? Did they feel impulsive?”

“Yes,” Janet paused and continued, “when I get upset I get a shot and they send me to my room, they don’t want to talk to me. I’m supposed to calm myself down. My son who is autistic is in the hospital. He’s in a treatment center right now, probably going through the same things that I’m going through right now. The Chaplain let me call my husband one day and find out exactly the name of the place where he’s at cause he said some treatment center in [the nearest largest city]—that doesn’t tell me anything, he could be anywhere. It was a cordial conversation—I could tell he felt a little uncomfortable—but he said that he is going to check and see about getting me on the call list so I can call and talk to my son…Then, I get back to the unit and staff confronts me, says that my ex-husband’s wife called. She said that I yelled at my ex-husband during the whole conversation and that I’ve been told never to call him during the day and all these other different lies that did not happen. The Chaplain was there and he called up to the unit, and he said that I didn’t yell during the conversation. And, I have yet to hear anything about being able to call my son.”

Janet and I continued to discuss her separation from her son and the ways she feels alienated from her family. While she has recently sent a card to her son, she has not heard from him and does not know whether he received the card. She also described how her sole source of support, her sister, had tragically died recently. I asked her how this diagnosis made her feel, as it seemed to validate her feeling abandoned.
“The first part of it fits me really well, but I feel like I wasn’t struggling in my twenties. I feel like now is the time I’m struggling with a lot of things.”

“So, the whole part about your struggles starting in your twenties doesn’t really fit,” I reflected.

“No. It’s just been the last few years that I’ve really been struggling with a lot of issues,” Janet replied.

“Do you feel that it gets at your strengths and weaknesses?” I asked.

“I don’t know that it really talks about my strengths,” Janet replied.

“Do you feel that it would be helpful if it did?” I asked in response.

“Yeah,” Janet said but did not expand her answer.

“Would you add anything to make it more accurate?” I asked.

Janet paused and reflected for a few moments. “Well, like I said before, I would be getting better if I was getting the help that I needed.” While I assumed we were still on the topic of strengths, Janet returned to the topic of treatment. It appeared that Janet did not see how her treatment was connected to the DSM diagnosis of borderline personality disorder because, if it was, she would be improving.

“So anything about treatment that would be helpful, like things to work on?”

“Yeah.”

I moved to my next question. “Does this help at all in giving you some hope for the future?”

“Right now I feel more hopeless than anything,” Janet replied mournfully.

“Does reading this make you feel any more or less hopeless?” I asked, intending to focus on the diagnosis.

“If it had something in there about treatment about what can help a person with these kinds of struggles, ‘cause that seems to be what's lacking here at this hospital—and I know I wouldn’t be the only one who would say that.” Janet seems to be saying that the lack of treatment options in the DSM diagnosis made her feel more helpless. Furthermore, because Janet felt as though she was not receiving the appropriate treatment, the lack of treatment options may have stood out to her.

“Do you think hearing that at the beginning of therapy would help, with the individual therapist?”
“Yes.”
“Going over it, and this is what we can work on together.”
“Yeah.”
“Is that something you would feel comfortable with of other people knowing, like people who are involved in your treatment, like doctors, nurses or even insurance companies?”
“Would I feel comfortable with other people knowing?”
“Yeah. More in general just—”
“Yeah cause then maybe I would get the help I need. I mean no one has really sat down with me and talked to me about my diagnosis.”
“You got a little of that at the place you were at before. It seems like they told you a bit about it there.”
“Yes. I mean here, the ironic thing about the whole thing is I’ve been getting cards and letters from a good friend who was in the group home with me. She’s been sending me a lot of cards and letters telling me what is going on and the group home. They’re now having anger management classes and they are having borderline personality disorder classes. They are having all the things that I need, so, what am I doing here? They’re having all the things that I need except I’m here because I throw one temper tantrum while I’m there at that place. They send me here thinking I was going to be a totally different person when I got back, and what I’d like to do is take every single person and kick them in the butt and say ‘Why did you send me here, why did you do this to me?’ I got better help there than I am getting here. I don’t want to be here any more, I don’t want to be here any more. I feel like I would be getting more help at home that I am getting here.”
“And you weren’t having these classes when you were there?”
“They only started the anger management classes when I was there. They just now started the borderline personality disorder classes.”
“You’ve had more trouble with this since you’ve been here.”
“And I didn’t even know I was coming, I knew I was on the waiting list but they never told me that I was actually coming. One morning, they woke me up at 5 o’clock and told me to get up and they threw a bunch of things together and sent me up here in a police car with a policeman who had an attitude ‘cause he didn’t want to make the drive all the way up here and he took it out on me.”
“It seems like it would be difficult to feel good about coming here with that start,” I said. While Janet was tearful throughout the interview, she began to sob at this point. I said a few words to reassure her of my presence but we mostly remained quiet. I asked Janet if she would like to continue, and she thought it would be a good idea to do so.

I introduced the next part of the interview and set up the idea of a hypothetical therapist. “I want to do a little bit of an exercise with you. Think about if you were just starting with a therapist that you hadn’t met yet, but all you knew was that she or he was using this understanding to try to help you. What were your initial thoughts about this?”

Janet replied, “I would be confident that I would get the help that I need.”

“What about that would make you confident?”

“That you would have background information on my condition. And, they wouldn’t care about how many panty liners I used. That was the most ignorant conversation I’ve had with a therapist, and that’s why I got upset.”

“Because he didn’t want to talk about the things you wanted to talk about?” I asked, but Janet did not appear to hear my question.

“And, of course, that goes on my record, and now I’m afraid I’m going to have to stay a lot longer than originally, over something like that as trivial as that.”

“This hypothetical therapist that we are talking about, do you think he or she would understand you, using this?”

“Yes.”

“Would she or he trust that you, the things that you were saying about how were feeling and the things you were doing, um would he trust your experience of what’s going on?” I asked.

“He should because I’m the one who is going through it, and I should know,” Janet explained.

“Do you think this understanding would help him do that or take away from it?” I asked, trying to understand how Janet construed the diagnosis and how one might use it.

“I think it would help. I don’t know how much people know about borderline personality disorder but having treatment options in there would give them somewhere to begin as far as treatment is concerned. They wouldn’t be starting from scratch.”

“So, it would be like they would have an initial kind of start about where you’re coming from?”
“Yeah.”
“And they could change it as they talked to you more?”
“Yeah.”
“Do you feel like this therapist would be willing to revise their understanding as time went on?”
“Do you mean my therapist?”
“No, I’m talking about this hypothetical therapist we just made up.”
“Do I think they would be willing to change it? Yes,” she replied. I found myself having more difficulty understanding her, asking her questions about the diagnosis, as her responses became shorter.

I moved to my next question, “Do you think a therapist using that understanding would think that you have the ability to change?”
“Yes.”
“Can you say any more about that?”
“I guess what I would think is that if they were a competent therapist they would be able to come up with solutions to the struggles that I’m having and find ways that would help me overcome them because to me that’s not my job. It’s their job to be able to do that.” Janet seemed to convey that the diagnosis itself did not matter but the therapist’s ability to devise interventions that would be helpful.

“So, it’s more about how competent this therapist is regardless of their understanding, it’s his or her responsibility to come up with solutions,” I reflected highlighting the notion that the therapist held the responsibility to help her.
“Yes.”
“So, it sounds like if a therapist was using this diagnosis you would find the therapy helpful because you have a starting point something to work on, but it would also matter how good this therapist is,” I reiterated.
“Yes.”
“Do you think this would help people in general, this type of diagnosis, with similar struggles?” I asked trying to help Janet abstract a bit more from her experience.
“Overall, yes.”
“`I'm curious what makes you say ‘yes.’ Can you tell me a little more about that?”
“Like the first couple of pages, I can picture myself in your description,” Janet paused for a few moments looking over the diagnosis, “there is really nothing specific.”

“It’s like having a starting point, having something to work on, something like a shared understanding.”

“Yes.”

“It’s kind of like you were saying before about your treatment plan and your discharge criteria. You feel it is important to have a shared view or understanding with the people who are trying to help you, so everyone is on the same page. That’s important to you.”

“Yeah. And I don’t feel like they are.”

“Do you trust a therapist using that understanding, with what you’re going through, and feel comfortable talking to her or him?”

“Yes.”

“Is there anything else you want to say about this one?”

“Like I said, the first couple of pages fits me to a tee.”

“Ok.”

“Those three pages. The only thing doesn’t fit me would be like the last couple of, like the last paragraph or so.”

“This part here?”

“Yeah.”

“And you like the beginning part?”

“Yeah.”

“So overall you find this to be a pretty good diagnosis?”

“Yes.”

At this point, Janet and I took a break, as dinner for her unit was starting in about twenty minutes. Before we moved to the experiential constructivist diagnosis, I wanted to have a somewhat richer understanding of some of the issues brought up in the DSM diagnosis and asked more specific questions about her reactions to the diagnosis. “I wanted to ask you before we move to the next one, I should ask you maybe some more specifics. You said there were a few things you liked the descriptions about feeling abandoned, and a few other things in the first few pages that fit. I was wondering if you could talk about those a little longer before we move to the next one. Would that be alright?”
“Yeah,” Janet replied, and I grew more concerned that she would have difficulty answering some of my question because of her level of distress.

“So, you said that the abandonment fit for you—what about it did you relate to?”

“Well, I have trouble being by myself, being alone, I feel like I need to have other people around me. And, I guess I’ve gotten myself involved in relationships where it was hard for me to spend time apart from that particular person…And, like I said I almost feel like I’m being abandoned by the staff as well because they don’t talk to me and remind me to talk. They don’t have time, and, you know, and even though I am friends with a client that I can confide in over certain things, if I get to the point to where I get too upset, she kind of backs away from me. You know, I don’t want to have to deal with being upset all alone—I feel like I’m being abandoned by people.”

“So, you think you confide in people and then when they see you getting upset, they back off and then that leaves you alone again?”

“Yeah.”

“When you feel abandoned how does that make you feel?” I asked.

“It makes me feel sad and frustrated and helpless and hopeless,” Janet explained. She paused for a few moments and continued, “To tell you the truth, I cry more than I get angry, I get hurt more than I get angry. The only times I really get angry is when—I’m using the panty liner issue again—when like for I’m using the panty liner issue again, something that’s totally irrelevant from what I need at the time or to what my problem is. Or, when people ignore me and don’t want to listen and help me I get angry, if I don’t get what I want right at that particular time.”

“If you are not getting the support you need in that moment?” I replied. “Yes,” Janet answered. “What else was useful for you in terms of this issue of abandonment?” I asked.

“Like being involved in a relationship. When I was in one group home, I got involved in a relationship with somebody else that’s there and it was hard for me to be apart from this person. I did demand to spend a lot of time together with that person and at the end of the day, when it was time to go to bed or whatever, it was hard for me to separate from that person. I don’t know maybe it’s because I felt like I didn’t have anything or anybody. And, here I finally had somebody and I just don’t want to let go of that.”

“So, you are afraid of getting close to someone as well as fear of being alone?”
“Yes.
“You were afraid to separate?”
“Yeah.”
“What else was there?”
Janet paused to look over the diagnosis. She reflected for a few moments, “Well, I’ve never been one to be that self confident, I’ve never really felt that good about myself. And, I guess, you know not having the support I need makes me feel worse about myself—like I’m not worth it.”

“Not worth having someone to support you,” I replied.

“Yeah. You know, like I said before, if I get upset, if I’m upset about something here, if I'm crying or whatever, they make me go to my room,” Janet said.

“And then you feel alone,” I inquired.

“And then I feel alone. And, that’s probably the worst possible thing you could do is make me go to my room and be by myself, ‘cause that’s when I get in the mode of possibly throwing temper tantrums—yelling and screaming.”

“When you’re by yourself in your room?” I asked, as I assumed Janet had “temper tantrums” when she was with others.

“Yeah, ‘cause I feel like people are pushing me away,” Janet explained.

“So, it’s like your fears about being alone feel like they become true at that time?” I asked.

“Yeah. And, then I can hear them up at the desk laughing or joking about something and why can’t they spend that time talking with me, if they’ve got enough time to joke…And, it seems like they do that to a lot of people, the staff. It seems like the time when a person needs to talk the most, that’s when they push you away, and then you see them sitting around and doing nothing half the time,” Janet said softly and very slowly.

Presentation of Experiential Constructivist Diagnosis. I handed Janet the experiential constructivist diagnosis and she spent some time reading it. As we proceeded with the interview, I saw that Janet became increasingly upset. She was very tearful and answered my questions very slowly and behaved differently from our first meeting. While I asked her a few times if she wanted to continue at another time, she said that she preferred to meet with me today. Janet
interrupted my thoughts by saying, “This is perfect. I read the first sentence and it hit the nail right on the head,” Janet said with some happiness.

“How so?”

“I mean everything you say, I mean it is the story of my life, I mean there’s nothing in there that isn’t true.” I allowed Janet to reflect upon the diagnosis a bit more and she continued, “How I grew up does affect how I react to things today and it affects all of the relationships I’m in.”

“So, it describes your life, it describes the way you struggle now as well as how your past may have affected your present?”

“Yes. Because when it got to the end of the relationship with my husband he started to become abusive as well. Physically abusive. I had bruises with his fingerprint marks on my arms, and it was all because I was sick and he would treat me that way in front of our son.” As Janet said the word sick, she began to sob. I attempted to be supportive and after about ten minutes realized that rest of our interview would need to wait for another day. While we discussed the diagnosis, these conversations were brief. For the next hour or so, Janet cried and described the mistreatment she experienced and some of the ways it connected to her childhood. While important to Janet, the interview deviated so far from the study that I chose not to include it here.

Janet and I found another hour to meet four days later. When we met Janet seemed to be more present and stated that she wanted to meet to finish our discussion. I started by asking Janet if she had any thoughts about the diagnoses since we last met.

She replied, “A little bit.”

“What have you been thinking about them?” I asked. Janet did not respond, and, after a few moments, I described where we had stopped with the formal interview.

“Yeah, on ‘B,’ [B is the experiential constructivist diagnosis; A is the DSM diagnosis] the whole thing fits me really well, where on ‘A’ there are parts of it that fit and parts that don’t quite.”

“Did ‘B’ make you feel hopeful about change?”

“Yes,” Janet replied.

“What about it made you feel more hopeful?”
“Because there were sentences in there that were more positive and made me feel more positive.”

“Yeah, you had pointed that out last week. You said that it was more accepting, more caring?”

“Yeah,” Janet replied. While Janet was clearly engaged in the interview, she continued to struggle to put her experience into words.

“I think you had said that it made you feel good.”

“Yeah.”

“Did it make you feel stronger as though you could see yourself in the future?” I asked, as I thought she had implied feeling stronger in the previous interview.

“Yeah, it means I’m more capable, it gave me more hope.”

“You also said that you didn’t feel it told you what you need to be doing?”

“Yeah, I mean as far as my treatment goes,” she replied.

“What did you take from ‘B’ that made you think about treatment,” I asked, as Janet seemed to be most interested in concrete plans regarding her treatment.

Janet paused for a few moments. She laughed and said, “I'm not good at this.” When I asked her what she meant, she replied that she had trouble trying to explain her answers in more detail. I tried to reassure her, but, in hindsight, wondered if I missed something important by trying to assuage her fears.

Janet seemed reassured, however and continued, “Well, I guess in some ways it’s almost like it gives both sides of things and, at the end, it’s kind of a solution to it…Like I’m just looking at the first page, where you say, ‘At these times it seems that you also see others as accepting and caring, which allows you to be more flexible with them and at other times it seems as though you understand yourself as angry and are less accepting of your emotions and actions.’ That gets like both sides and, then, you end in saying that, ‘at these times you may fear others as they seem most dangerous and hurtful. Integrating these two sides of your self may be a struggle that may allow you to feel more solid and stable.’ That kinda gives both sides again, and a solution. Kind of bringing it together.” Janet thought these parts of the diagnosis not only provided some options for her, but also described her strengths and weakness, as it provided “both sides” of her self.

“And that’s a solution that makes sense for you?” I asked
“Yes,” Janet responded.

“Do you remember I had asked you to pretend that a therapist, a hypothetical therapist, was using each one of these different understandings?” Janet nodded and I continued. “Do you feel more understood by one or the other?”

“Yes, I feel more understood by ‘B’ because it fits me better.”

“So, would you trust one therapist more than the other?” I asked.

“I would probably trust therapist ‘B’ a little bit more than I do ‘A,’” Janet responded.

“What makes you say that?”

“Because there are some things in “A” that really don’t fit me, I mean there are things in there that do fit, but not all of it.” Janet explained.

“Which parts do you feel don’t fit in ‘A’?” I asked.

“When you talk about displaying impulsivity, you know I wouldn’t actually do any of those things that you have listed.”

“Would you be worried that therapist A would be thinking that you do those things?”

“Yes, because I don’t. And there’s a part that says, ‘Individuals with such struggles have undermined themselves at the moment a goal is about to be realized.’ And, I don’t think I would do that. If I see that a goal is about to be realized that would be the time I would go for it. Getting started might be difficult for me but—And, if it’s something that I’m good at, I basically have more self-confidence, than if it’s something that I’m not good at.”

“So it really depends on what you are trying to do?” I asked.

“Yeah, it depends on what it is,” Janet replied.

“So, it sounds like if it was something music related, you would feel more confident about it?”

“Yeah. And, back when I was married, I was involved in Right to Life and I was secretary of our county’s chapter. I wrote a lot of articles, wrote a lot of letters for the paper and was really involved in that. I was the one who came up with new ideas and initiated the things we did. Something like that I would go full speed ahead on I wouldn’t have any undermining thoughts or insecurities about my abilities in performing in that area,” Janet elaborated.

“Sounds like if you are passionate about something, you feel more confident,” I replied.

“Yeah. See and I’ve lost that now, too. I just feel like I don’t have anything that makes me feel good as a person.”
“That sounds difficult…Moving back a second, are you saying that it would be important for your therapist to know these things about you and how that part of the diagnosis doesn’t fit? Would it affect your ability to trust that person if in the back of their minds they were thinking that you were doing these things, the undermining?” I asked, moving back to the notion of a hypothetical therapist.

“Yeah.”

“As we have talked, it seemed to me like being understood is really important piece of trust for you.”

“Yes. And then like the last paragraph where you mention that, ‘The most common pattern is one of chronic instability in early adulthood.’ And, I didn’t have any problems in my twenties, I mean I had a little bit of OCD, but it wasn’t something that kept me from living my life. Once I left the house I was ok, I never gave it a second thought. And, it seems like this just started a few years ago. So, it actually started in my forties, it just happened all of a sudden, I don’t know what caused it, but I just started having panic attacks, and once that—it could have been due to all of the stress I was feeling because of my relationship with my husband at the time, and having to take care of our son who was a special needs child that took a lot of extra energy.”

“You had a lot of stressful things going on, around that time.”

“Yeah, and it just all built up to where I couldn’t take it any more and I started having panic attacks and after that everything escalated. I got depressed, my OCD got worse, I had a lot of anxiety, tons of it. And, that’s why I’m in and out of the hospital all the time.”

I returned to my questions, “Do you feel one or the other makes you into a victim at all?”

“I don’t think it necessarily makes me feel like a victim, just describes what I’ve gone through. Especially as far as ‘B’ is concerned, I mean it’s the truth. There are some things in ‘A’ that don’t fit,” Janet explained, possibly hinting that some of the information in the DSM diagnosis made her feel as though she were a victim.

“It seem like your thinking about each therapist would change depending on which diagnosis they use? How do you feel that would affect your therapy with that person, your treatment with that person?”

“Well, I believe they whatever they read they are going to picture me as—that’s how they are going to see me as soon as I walk through the door. And, they may make judgments about
me before they even talk to me. And they will, they are human, I mean I would, and if there is anything in there that is not quite right that’s already getting off to a bad start in my opinion.”

“You would probably be worried that they would be looking for a way to make that piece fit.”

“Yeah.”

“Kinda like the panty liners?”

“Yeah, because I have the diagnosis of OCD, they are reading into something that is not even there. I wear them because I need them, I don’t wear them because I feel—I don’t go to the store and buy them by the box carton full. Now that would be obsessive. That would be an obsessive behavior if I would go to the store and I have a carton of panty liners, but that’s how they are looking at it. They are looking at it, like I use 72 of them in so many days, and that’s not true, that’s not true. I may have had that many in my possession, but it’s not that I used them all in 2 or 3 days. It’s just an insult to me, it really is an insult to me that Dr. Evert has to say to me, ‘Now you can wear only three of them a day.’ And, if I use them up before a certain time I don’t get any more…And, it interferes with my treatment, it definitely interferes with my treatment. I worry about it all the time, where before it was an everyday ordinary thing that I had to deal with, and now it’s become some huge monster that’s sitting on my shoulder…I feel like I am being treated like shit.”

“It seems as though you do not feel understood,” I paused and continued, “Do you think the therapist sees your ability to change any differently depending, does therapist “A” [DSM] or therapist “B”[experiential constructivist] have more hope for you, you were saying “B” gives you more hope do you also think therapist B has more hope, and trusts your ability to change?”

“Yes,” Janet replied.

“So, do you feel like the second one would be more effective for you?”

“Yes,” Janet replied.

“This is my last question. Do you prefer one over the other?”

“I prefer ‘B’ over ‘A,’” Janet replied.

“Why is that?” I asked.

“Well, it describes me better, and, for me, it was more readable.”

“More understandable you mean?” I asked. “Yes,” Janet replied. “What made the first one hard to understand?”
“I guess maybe the bigger words,” Janet replied. I wanted to make sure the DSM diagnosis was understood, and I asked if she felt as though she understood the diagnosis and if she wanted me to go over certain parts. Janet said that she did not remember but added, “I think more than anything there were parts that, that I myself didn’t relate to in ‘A.’”

“So, it may have been that certain parts did not fit for you very well and less of a problem with understanding?” I asked. “Yeah, it didn’t seem to fit,” Janet replied. “So, it was harder to understand those parts, the parts that didn’t fit,” I asked. Janet answered in the affirmative and, at this point, we concluded our interview. After discussing the project and debriefing Janet, I asked if she had anything questions or wanted to add something. She said she had things to say, but they did not have much to do with the project. She said while answering some of the questions were difficult because she was stressed, the project had helped her. We spoke for a few more minutes about the things going on for her before concluding our discussion.

David

David was a 33-year-old Caucasian man who had been admitted to the hospital about nine months before we met. In the last 10 years, David said that he had been hospitalized over 25 times. David attributed his frequent hospitalizations to his abuse or misuse of the mental health system, which will become clear in my description of our conversation. He was admitted to the hospital in which we met due to psychotic symptomatology and destructive behavior towards self and other. David also has a long history of suicidality. In some of these instances, he intended to die, but, in most, he reports that he attempted suicide to bring attention to his pain. At times, David himself was unclear about his intentions to kill himself. David often seemed confused, and he expressed concern that everything seemed confusing, cloudy, hazy or muddled. I found it easy to feel his confusion when speaking with him, as his speech was very fast, he moved from topic to topic very quickly and would interrupt a thought to begin a new one mid sentence. More often than not, David would censor himself, as some experiences and thoughts were too painful and humiliating to be put into words. At times, I found it difficult to hear David’s words and attempt to construe his experience, as David’s experience was very dark and his behaviors often destructive. At other times, I could easily see that David wanted to feel more fulfilled as well as the ways his experiences have halted this effort.

David and I met twice over a two-week period. Our first meeting lasted for roughly 2 and one half hours and was divided into two sittings. I will not focus on the last half hour, as the
Diagnostic Interview.  David and I began the interview in the mid-afternoon, while the hospital was busy with classes and activities. David did not attend many of his classes, and I invariably knew where I could find him—lying in his bed awake seemingly deep in reverie or trapped in his own thoughts. He appeared happy to see me each time I went to the ward to find him and enthusiastic about participating in the research. Walking from the ward to my office, David remained fairly quiet and seemed as though he would not say much. I began the interview by asking David to tell me a bit about himself.

“About me?” he quickly asked. “Yes,” I responded. “Well, I’ve been suicidal. I’ve tried—I’ve been obsessed with death since the age of nine. I tried drinking a cup full of 409 [a household cleaner] cleaner in front of my sister, ‘cause I made sex calls, and I didn’t want to get punished, ‘cause my parents were not very—were very strict with me. I drank it, and ever since then, I’ve been like—I’m confused by my life, and I’m gonna ramble on from subject to subject ‘cause I have a problem with that.”

“Well, if I’m not sure, I’ll ask you,” I replied quickly, matching the pace of his words.

“Ok. Well I’ve tried, I’ve been trying to commit suicide so many times for attention and ‘cause I want to die. Part of me wants to live, part of me wants to die. I’m all obsessed with things. I’m just so like messed up that I mean, I don’t know where to begin. I mean, ‘cause life’s just never been good to me. I’ve been criticized for 18 years of my life. And, when my mom would say, ‘Who do you think you are?’ I’d have to put my head down and say, ‘No one, mother.’ And I want to say, ‘Oh, my name is David Tompkins.’ I wanted to say my name, and she wouldn’t let me, you know? My mind—I’m like—I’m beaten down. Like my step-dad would never correct his sons, my stepbrothers. He’d make me and my sister pull down our pants and underwear and beat us with a belt. He corrected us. I’ve engaged in homosexuality acts with people. I don’t—I mean I’m confused about my sexuality.”

“He forced you to do—” was all I was able to say before David said, “No, not sexual or—he made me take showers with him at an ungodly age. Not as a teenager, but I think at about 6, which I do not think is right. And, this kid, when I was younger, made me put my mouth on his penis, and I’ve been confused with my sexuality. I’ve been with men and with
women. That’s why I’m so rambling on—my mind’s so messed up. If only things could’ve been better. But, you can’t go back and change the past, but I want to succeed in life. I want to do things, but I just keep on dwelling on the past. And, I’ve had so many therapists and everything. I’ve been hospitalized over 25 times in now 10 years. I tried beating the system, tried to play the system. I don’t know if I got a mental illness. I’m so obsessed with death, and I want to see what it’s like. I don’t want to burn in hell so I don’t—I want to take my life, but I don’t want to burn in hell. I’m havin’ spiritual battles. And, if I could—shit—my life is so messed up you couldn’t even get it to straighten, you can’t get it together, and things jump from here and there.”

At this point, I felt a bit overwhelmed with the amount of information David had given to me as well his urgent way of speaking. David had difficulty stating that he felt what his stepfather did to him was wrong, something that will arise again in other parts of the interview. These violations seemed to have made experiencing safety in the world a difficult undertaking, as it seemed as though David’s inner life was confusing and fleeting. As David points out, it was difficult for him to figure out if he should take his own life.

I started to reflect that it seemed to feel very confusing, but David cut me off, a fairly common occurrence in our conversations. “Yes. Everything’s hazy. It all started when I drank that 409, before that things were pretty alright. You know? I’d be okay, go along, except for what my stepfather did, what he did to me and my sister. And, I can understand he’s trying to correct us—and, hell, I’ve even been kidnapped. This kid, he said, ‘Won’t you come with me?’ And, I did. And he said, ‘I want to put your head through there.’ First, he put me in a car where I kicked the window and my stepfather saw me, and he took me out. He took me down to the gas station to get a pack of gum. But, I suppose that’s the only time I’ve ever been kidnapped. But, I mean I’ve done stupid things, and I’ve had a family that I never—I was never brought up the way I wanted to be brought up.” I was curious about his statement, “I suppose that’s the only time I’ve ever been kidnapped.” It was as if David expected to be kidnapped on multiple occasions. With his words, David conveyed a tension between being aware of the effects of painful experiences and the avoiding the ways people have hurt him. For instance, he described everything being fine before drinking a household chemical, even though his stepfather would humiliate and beat him. Finally, he said the words “correct us” in such a cold and matter of fact manner that it sent chills through my spine. The words had a very old and worn quality, as
though they had been used in childhood and repeated thereafter. *He said this phrase throughout the interview, each time delivered in the same way.*

“How did you want to be brought up?” I asked. “The Christian way. Prayed daily, respected…if we could change our life, but can’t change your past…you can’t always say, ‘Oh, this is or that. Poor, pity me.’ That’s what I do. I pitied me, I pity myself in the past. I look for pity and reassurance and self—I mean show, show of attention. But, deep down inside I wanted to go on. I’m used to this. I don’t even know if I got a mental illness. I don’t know what’s wrong with me. And, I hear these like, not voices outside my head. I hear, like, what I’m doing now?”

I paused to try to understand what he meant, but I waited too long. David continued, “Can you hear what you’re thinking inside of your head? That’s what I do constantly. I’m gonna burn in hell, I’m gonna burn in hell. I think that. I don’t hear audible voices. I tell people I hear voices. But not audible. I tell ‘em I hear audible, but I don’t. Okay? I lie. I’m not lying to you now. Everything I’m telling you is the truth. I’m laying it all on the line for anyone who wants to hear it. But, um, if I heard voices I’d probably beat my head against the wall. I’d probably freak out. I don’t know what I’d do.”

“You have this thought that—” I began to say. “Yeah, it’s like I have this thought. I’m going to burn in hell, burn in hell. I mean—I seek reassurance—these people can’t hear us can they? I hope not.” David was referring to people outside my office door, hard to ignore, as two of the walls of the office were floor to ceiling windows covered with metallic blinds. I reassured him that unless we were talking very loudly they could not hear us. He went on to say that he did not care what they thought anyway and asked where we had been before the interruption.

“You were saying you have this thought.”

“Yeah, and seek reassurance for spiritual, godly—to the people that I want—I don’t want to burn in hell. That’s forever. It’ll never end. It’s like we’re sitting here, like never leaving this spot. But, I think that over and over, and I do things. I slashed my wrists, and I take pills. And get my stomach pumped. I’ve done this so many times. Say the devil made me do this and I hear voices. I mean I’m—I do have an anger problem. I do have—beat two women. I’ve hit some women. I feel real feel low about that. I think I saw—growin’ up with my step-dad being mean to my mom and everything. I’ve had—I’ll get to it in a minute, I’ll get down deep. But, I grew up in violence. My step—my real father left me when I was three years old. I didn’t know
about that. He’s an alcoholic. I called him one Christmas Day. I got his number and I called him, and I asked, ‘Is this Brian Tompkins?’ And he said, ‘Yes.’ I go, ‘This is your br—this is your son, David.’ And, um, we’ve been having a relationship here and there, and I’ve been using him for my advantage. To get what I want ‘cause he was never there. Because I want to pay you back for the hell you put me through. He sends me this stuff, and I give it away. But, he won’t send me down to see him. And I think—I don’t understand why.”

“You really want to get to see him.”

“Yes. But why won’t he send me down? Is he afraid to—I really want to, I don’t understand. I’m afraid to—I go down there and see him and when I see him, I’ll tell him I’m gonna get violent with him. Or, say I don’t want to see you again, but I don’t want to do that because that won’t be the right thing to do. I used my mother ‘cause of the things that she’s done to me. And I’ve called her ‘bitch,’ and I can’t believe that. ‘Cause she’s never been no mother to me. I’ve used her like the way I used my father. I use people. Sometimes and sometimes I don’t,” David responded. David described not understanding why his father would not want to see him in the same breath as saying he would tell him that he would be violent with him if he saw him.

“You say you use people,” I said.

“I mean like, to get what I want. I say poor pity me. Or, I tell Mom, ‘Oh I need this now.’ It’s not myself. I know I’m not myself. I can sense it. I can feel that deep down inside it’s not really me. This would be before I got all this stuff at the age of nine I used to be real fine. I was a nice person, nice kid. Then, this is where was I going to go next, this is low. I’ve had incest, child molestation, had intimate sex with my sister. We had a baby with it. I never told my parents about it. We thought they didn’t—she told them she didn’t know who the father was. I had sex with married women. I have a baby that’s really mine. Well two of ‘em are mine but this one is, I, he’s nine years old. The first one’s 16 going on 17. The other one, I’ve been out of his life for eight and a half years. And neglected him real bad. I wrote him a letter while I’d been in the hospital twice. In the second one, I told him that I’ll always love him, told him I would love him no matter what and be thinking about him no matter what. He’ll always be in my heart. It’s best, it’s best at this time that I leave him alone, I’d bet people would agree with that ‘cause you don’t want to mess up a nine year old like that, so he won’t inherit the mental illness. ‘Cause his mom has—I met his mother in a private hospital. And we had sex and both
had mental—but I don’t know what I have wrong with me, ok? And, we had a baby and we were both on medications. So, I don’t know what’s wrong with the baby. I don’t know if there’s anything wrong. He’s hyperactive, but I don’t want to mess him up anymore—but I don’t want him to get—mess him up anymore.”

“Who’s the other mother?” I asked, forgetting that his sister had his first child.

“My sister. I was probably about 13, it’s very disgusting. Please don’t hit me, ok?”

“Me hit you?”

“Yeah.”

“I don’t want to—,” I was unable to finish my sentence. David appeared to think that I would punish him or correct him for what he had done. Or, his behaviors would be so disgusting to me that the only way I could respond was with violence.

David continued, “I was a six year old with a penis of his—I was messed up, man. I don’t know why I do this shit. I’m confessing to you like a father. I’m not Catholic. I never told my current therapist this stuff. I told some of this but not all this. I mean that’s why I’m doing this for you.” David style of approaching me, quickly telling me all the transgressions of his life, now seemed a bit clearer. For one, David treated this experience as something of a confessional; me playing the role of the priest and David the sinner. While I usually try to believe the words of others, I was having trouble believing that he was telling me, someone he just met, all of his secrets. David seemed to be trying to make feel special. But, David did not need much to tell an other person very intimate details about his life.

“Why didn’t you talk to him about it?” I asked.

He responded, “I dunno. I mean I like him, I like him a lot. This is for all you guys [reference to the diagnostic group], who are doing the research. I’m going to let you know everything about me. This—I mean, you’re probably thinking, ‘What in the hell?’ I know I jump from subject to subject. That’s how I am…I can’t concentrate but for shit. When I graduated from high school, I tried to join the Navy, I tried to hang myself in boot camp in front of fuckin’—excuse my language but I curse I a lot—hang myself on the damn second week of boot camp. I have a bad heart. I passed my physical, but I lied. It took me three years to pass that test to get into the military. And then I tried, I tried college and I partied on the first week and got on academic probation, I screwed that up. I faked seizures half the time in Texas to get out of—to get attention. I do things for attention. I don’t know what is wrong with me, I mean,
there’s gotta be something. But, if there is, I’d like to know what it is. Gosh! All this crap that I do, and all this stuff that happens. I tried really to commit suicide twice, two times really. First time was with my first wife. I hated her, and I was 19 she was 21. But, I married her ‘cause ‘cause for alcohol or pussy or whatever, sorry.” David moved from discussing his relationship to his therapist, to his bad heart, the lies he had to tell the Navy before hanging himself during training, to suicide and, finally, to his hatred for his ex-wife. David appeared to see others as means to some end but feels guilty for objectification of others. Additionally, in his message to the research group, David communicated that his experience of himself was so confusing that he would assume that others could not understand his experience. While it would be appropriate to infer that others stopped trying to understand his experience, these statements seemed to reflect a sense of inner chaos as well.

David continued, “I took a boxful of Benadryl down with a coke when I was living with my parents. My mother comes in and says ‘David, it’s time to eat supper.’ I come out there like walking like—they can’t see me—but you know how I walk, and, like that, and I’m shaking real bad at the dinner table, and they go, ‘What, you take drugs?’ I go, ‘No.’ I told them ‘I overdosed, I overdosed.’ And, they made me eat supper before they took me to the hospital. Isn’t that fucked up? And, then they called my step-aunt, my dad’s sister, to take me to the hospital. Made me drink charcoal and then I got admitted. And the next, the second time, I can’t remember what I really did the second time for. It was a real attempt too. So, I’ve done a couple—I think I’ve done more than one, at least twice, I’ve really meant to do it. Call for help. When I took those Benadryl, I was serious. I didn’t even ask for help. I didn’t call 911 like I usually do, like I do for attention. I told you I did before—I was definitely wanting to do it that time. I just laid in my bed and, nothing happened—that’s weird. And, I saw a ghost. I probably did, I was on the gurney, I said, ‘Who’s that man right there?’ They said ‘Who?’ I saw a man like in a 1920’s outfit with a hat, and he’s was just walking by through the wall walking to where the EMT stuff is. I saw him just walk on by. And no one saw him except me. I was like “What in the hell?” I mean I believe in Satanic stuff. I feel like—I’m gonna burn in hell. I never engaged in Satanic performances but, I mean, but I’ve dabbled in stuff. Like I’ve never been to a séance or sacrifice, but I’ve done cruelty to my sister. I’ve pissed in a cup and made her drink it. I didn’t make her, but me and my friends did things like that. I stole from my grandmother—this is bad. I stole her credit card number and charged sex calls on it. And then,
shoplifted and stole, gave a controlled substance called Ritalin to high school students. They put the kid in the hospital with a 103 temperature. And, the judge said that I’m lucky, ‘You’re 17. I’d give you 25 years and $50,000 fine.’ All I got was 20 hours community service, $10 fine each month, maintain C average, stay away from school for 6 months, and that’s all I got. And that’s a miracle. This day, this day and age, your ass might be sittin’ in prison for a long while, bein’ someone’s bitch probably…See, I’m confused by my sexuality, and I don’t know what to do. And, I’m confused by everything and it’s like everything’s like haze. And I mean that’s why I jump from subject to subject. I can’t focus and, these doctors don’t know where I’m coming from. What I’m doing now, I wish they could hear this. I wish the doctors, I wish Dr. Aloysius [the psychiatrist on his ward], or anyone could hear this and understand what I’m trying to say, then come to a conclusion about who I am. I’m not no damn schizoaffective. I know I have up and down moods, like I do right here. But, I don’t know if I have schizophrenia. I don’t like people seeing over my shoulder because it gives me the heebie-jeebies, you know. Is there anything? I mean, if you want to ask questions, you can ask.”

“Thanks, I have a few. You said you were married twice?” I asked.

“Yes. I never even divorced my second wife. But, we were married for—”

“Wait. You said you never divorced your second wife?” I asked because I thought I misheard. David replied, “I don’t know if I am ‘cause she’s in Texas. We were married for seven months, I moved to a city a few hundred miles away, then I came back home. And, I never seen, I’ve talked to her twice since I’ve been back home. And, I’ve been here for seven or eight years now. Mm, other questions?”

“Well, I’m curious and wanting to hear about what happened in your marriages.”

“Well, I’m curious and wanting to hear about what happened in your marriages.”

“Um, violence. And, then they tried to control me. Alcohol, violence. And controlling.”

“Violence against you or you were violent against them?” I asked.

“Them, them. Oh no. I them,” he responded almost surprised that I even need to ask the question.

My next question was drowned out by some extraneous noise on the recorder, but I assume it had something to do with his children or parenting. He responded, “That’s all that all they say when you’re in parenting class, you are a model for your children that they see what you do, or that’s what they say. I grew up in violence. That’s not right. And I regret it, I truly regret it. I mean I’ve done such ungodly things, and I fear I’m burning in hell—so it’s like I tell
myself—I tell people, I say well Satan says to me: ‘Your gonna’ burn, you’re gonna burn in hell.’” David seemed to be aware that his upbringing had an effect on his behaviors, or, was parroting lessons from a parenting class. I could not be certain because David had adopted much of the discourse of the hospital. Throughout the interview, David would say things such as “You have to get over your past,” one of the mantras of the unit staff. “You know what I am trying to say?” David asked.

“It seems like you are thinking that you are bad or—” I started to say. I inferred that David experienced self and other in such loose and chaotic ways that his own thoughts seemed foreign. I tried to convey this to David.

“Yeah, I’m thinking, but in my mind, I can hear myself thinking. Not audible, but it’s hard to describe.”

“Is it like you can see your thoughts, and it feels like they keep moving and moving?”

“Yeah. You can hear the words running through your mind over and over and over,” David said and paused for a few moments. I used the opportunity to ask about his move away from his second wife. David answered, “Yeah, we separated and I just got up and went. I traveled around, go from place to place. I tried to run from my problems. I’ve been to California. That’s where it all began too, some of my problems. I called 911 there to say I’m homeless and to get a place to stay. I’ve been homeless there. I’ve been homeless New York. I tried killing myself there too. Funny story about that. I got my stomach pumped, and when I was leaving the hospital, a nurse said to me, ‘You look different with your clothes on.’ I go, ‘What do you mean?’ He goes, ‘Didn’t you remember running down the streets naked?’ I didn’t know that.”

“You didn’t remember it?” I asked.

“Oh no, I just blacked out. I was ICU for two days and then and—if you have any questions you wanna ask, just stop me, ok?”

“Sure.”

David continued, “I’ve never had a good life. But I’m gonna change it.”

“It sounds like you’ve had a lot of rough times,” I said.

“Well, it is, it is. I want to succeed. I can’t get myself to get my kick in the ass. And sometimes I need a good kick in the ass and tell me, ‘Just get off your ass and just do it. Quit being a sissy. Quit using it.’ I know I need help right now going through financial help, but I
don’t need it for the rest of my life. I’m going to make something of my life. I’d like to be like you, but I know I couldn’t handle the schooling, but I mean you got guts and you’re determined. And, I’m happy for you guys the people who read this—I want to do social work. Peer to peer things. I want to help people by telling them where I’ve been, I’m not going to tell them my life story but, because they’d go, ‘Why the hell, how the hell is he going to help me?’” While it David wanted to be more successful, he treated himself rather harshly when he did not.

“You know the territory,” I responded.

“Yeah. I can kinda feel something. I relate to some of ‘em. I done that, been there, tried it. You know, you’re not the only one. I know I’m not the only one who’s done all that stuff I told you, but it’s not right to do it. But, who am I to judge people? Who I mean not judge, judge, but there are people who think, “Oh, he can make a theory and come to a conclusion but I mean, I don’t—” David interrupted himself and asked me how much time we had left, and I assured him that we could pick up a later time if he wanted. He seemed happy to have this much time left but seemed to need my reassurance to continue. David hesitated for a moment, seemingly forgetting where he was. I asked him if I could return to something he had said earlier: “You started to say that your mother would say that—you would do something and you would hang your head. You wanted to say your name, she made you say you were nobody.”

“My answer was ‘No. No mother. No mother.’ She’d go, ‘David Tompkins! Who do you think you are, David?’ I’d go, ‘No one, mother.’ Like that.”

“How’d that feel to think—” I started.

In a quiet voice, David responded, “Low. I why, why the hell, why’d you have me? Why didn’t you give me up for adoption? Why didn’t you get an abortion? Why didn’t you give me up for adoption? That’s why—I think my life probably would be better if my mother gave me up for adoption. I think it would. Maybe have made something of me. I would I would contact her later on. She had a rough life, too and everything and it doesn’t mean she had to take it out on me. But look what happened? I can’t blame it all on her, but you know I chose to do the things I did. But, it’s up your upbringing that’s what it is. The way you get brought up.”

“I’d be curious to hear about that.” I responded.

“Like what, what exactly would you like to know?” he asked.

“Mmm, how was your relationship with your mom?”
“Well, I’m using her like I’m using my dad. I try to make her feel guilty even though she’s slowly deteriorating. She’s got scoliosis in her back, she got three deteriorating bones in her neck and right shoulder, I mean, right neck and left neck, spine things. She’s got carpal tunnel. She’s 53, I think, and she still works in the factories. She even has all that wrong with her and she’s in pain. I love her for that, but I’m still using her. And I make her feel guilty because she gave my sister all the loving. Now this I didn’t tell ya. Um, this is gonna shock—gonna be weird. When I lived in at home my sister tried to commit suicide, you know, ‘cause she was fat and no one liked her. And, well, I don’t know what the problem was, and she takes a knife and goes in the back taking the knife. I’m in the kitchen, eating and I’m watching, I remember this, the video for Whitesnake’s “Give me all your lovin’ tonight.” I’m eating brown maple sugar and oatmeal. And, I hear her in the kitchen the drawer and I go, ‘Oh, that’s normal.’ And she goes, ‘Well, goodbye David.’ And I go, ‘Ok.’ I think ‘whatever.’ I go in the kitchen and see a knife and I go back there and she’s sort of locked herself in the bathroom. I go call the sheriff, and he comes out to us. They talked her out. For eight hours, I don’t know, eight hours. No one called me, checked on me or anything. I didn’t know what to do. Now, that’s—hell—that makes me think I’m worthless, too. From when I was younger.”

David had mentioned that he felt his sister received more attention from him and this is one instance where he felt neglected. But, the way he describes his experience does not allow for any sense of what his sister was experiencing. By the song he mentions [this is unclear as the band and the title do not match up exactly], he would be in his late teens. From David’s report, his sister experienced the same abuse he did, but David has difficulty seeing that she was in pain also. Furthermore, I assumed that she would have already had David’s child without anyone knowing who the father was. *Not only did David have trouble taking the perspective of another, it was difficult for him to see his sister receive the attention he desired.*

“You tried to save your sister, but no one was helping you?” I asked.

“Yeah. No one. What about me? My mom’s never there for me. I mean she tried to be. She’s there when I don’t need her, and she’s never there when I need her.”

“Can you say more about that?”

“Well, like when I lived in Texas and I was married to my second wife before everything got bad, she would say, ‘I’ll come out and see you.’ For three years, I lived there. And, my sister now is a nanny in Massachusetts for her second time. She went out with her down there to
see her when she was in the hospital. She got real bad. She was there for thirty days but she went there to be by her side. I have been hospitalized so many times, she don’t like it. She wants to shun me out or whatever she wants to do. She won’t come down here. My step dad could drive her for three hours to see me. I mean, it hurts to think that she’s doing it ‘cause she don’t love me. I don’t know what’s goin’ on, but I feel like—it’s why I feel like it’s why I use her—because I don’t think she loves me. I don’t know what it is.”

“Sounds like you want some attention from her.”

David responded, “I want her to know me. I want her to know I exist and know the pain I’m going through. She won’t accept it though. I could never please her. She’d say, ‘You need to grow up. Act your age.’ I know I need to grow up and act my age. She needs to learn to respect my wishes. Give me the lovin’ that I need. I don’t need to use her no more. She needs to show me the love that—be there for me. Not always be on my sister’s side. Be equal.” David seemed to stop himself from thinking that he deserved her love without qualification and had difficulty saying as much. David seemed to understand himself in this and felt as though he did not even exist or did not exist in the eyes of others.

“Was it like this when you were younger?”

“In a way it was. Always got what I wanted, almost. Always got corrected,” David responded. I was confused by his juxtaposition of getting what he wanted and getting “corrected” and I asked, “Can you give an example?”

“Well, I ran away from home and school. I made demands that my dad shave his beard off, and all this and that. Give me these shoes. And she comes to the school. That day and um, that day and she goes, she scold me a little bit. Then, showed me love. And that’s how I got confused. I’m so confused with her still. Like I don’t know what’s—I don’t know. I think it would be better off if me and her could be pals, but I still think it’d been better of I was I was adopted out. I want to tell her that so bad that I afraid I’d hurt her feelings. But, I know if I were to call her a bitch and she’s never been a mother to me. What else can I do for her? Kill myself? Ha! I mean I want her to suffer. I mean this is weird too. I thought about killing myself on Mother’s Day in her house. In her own house. To make her suffer. I was gonna take some of her Lortab. Probably done it for attention. But, I wouldn’t do it at night. I would do it now or before they wake up, so that way I could be alive and they would know that and think, ‘Oh my God. He’s tryin’ to kill himself. Get the attention of her and I’d say, ‘You better wake up you
lady. You need to wake up and see that I love you. I want your love.’ That’s what I was gonna do.’

“You want to hurt her more than yourself.”

“Yeah, I wanted her to pay for it. I wanted her payback and that’s not right. You don’t need that from people, that’s not right,” David regretfully replied.

“Seems like you wanted to be treated better and are angry.”

“Yeah, I’m angry as hell. And, I shouldn’t be, I mean I should learn to forgive, but it’s hard. You have to forget your past and move on. I sit there and dwell on it all the time. That’s why I’m—look where all my life got me, right here—all ended up here. I’ve done it to myself. But some of these problems that I chose to do some of them are one’s I did to get attention. And that’s why I’m confused, ok? That’s all I have to say.”

“You got confused you’re confused because some of the things you wanted to do but some of the things you believed were for attention?” I asked, as I was feeling confused.

“Yeah, and I—that’s all I can say.”

“Okay, when you say you wanted attention, can you explain a little more?”

David paused for a few seconds, “Like a cry for help. Like, ‘Hey you better take me serious.’ I like getting’ waited on. I like getting free stuff. Like stuff like that. It’s like I’m a manipulator. And I don’t and I don’t wanna be a manipulator. I want to earn my keep. I used to have two jobs. I used to like work, I did. I love work. I mean I would love to be—I love to work, lift weights, go to church, try to read the Bible. I wanna live the perfect life. I know there’s no perfect life but live the life that I would love to have. To go work, go to church, go to the YMCA and work out, go fishing if I had time, read my Bible at home, watch Godly channels. And just not drink anymore. Not dip no more, not swear no more. Not do ungodly things like I done before. I want to do that. I want that so bad. ‘Cause I’m used to this lifestyle. I’m living for the now. I mean I’m used it. And how do I get off that? I don’t know! I just want off of it. I need the support of the system right now to help me to help me do my income, but I want, when I get out of here, to get a job as soon as possible. One that I can handle and I know I can handle it, until I get my degrees and college and finish it slowly. Take my time. I’ve done my duty, and I’m sorry for using the system. I truly am. I regret it.” While David wanted to change his behaviors, it seemed difficult to see himself as a person that did not manipulate and objectify others. For instance, throughout our interaction, I felt as thought David wanted me to feel
special (and accept him) and wanted me to be either be afraid or find him disgusting (and reject him). I assumed that he was unaware of how he made me feel.

“Why do you feel bad for using the system?”

“Because I’m making taxpayers use money on me that they don’t need to use,” David responded.

“I’m confused. It seemed like you were saying that you were using it but didn’t need to, but now it seems like you are saying you need it right now.”

“It’s both. It’s both ways. A contradiction. And I could live in a shelter. I wouldn’t mind, but it ain’t perfect. I can’t go back to my—I burnt too many of ‘em. But, hell they burnt me too,” David responded.

“You can’t go back to your parents you mean.”

“Yeah.”

“Was there a lot of physical abuse in your house, physical violence? I asked.

“Mostly emotional, verbal. Little physical—but mostly verbal and physical,” David responded, contradicting himself.

As he mentioned his step dad’s violence earlier, I asked more directly, “Did your step dad hit your mom?”

“Couple times and,” David trailed off and paused.

“You seemed to say that there was some sexual abuse, too.”

“Yeah, a lot of things, I am confused about. I don’t understand it. I mean I don’t know if I have mental illness or not. Do you think I do? What would you say? I mean, be honest. I’d like to know,” David asked.

“Well, in many ways, that question gets at the heart of this project, so let’s leave that to the side for now. But, it does seem like you’re struggling to figure out who you are.”

“I am. I don’t know what the hell the hell’s wrong with me. It all happened after the age nine and went all down hill.”

“Can you describe more of what happened at age nine,” I asked.

“Yeah, I was masturbating and calling sex lines. The phone bill came to $300 and I blamed it on my step dad and, I didn’t want to get punished. I got my ass beat with a belt on my bare ass, ‘cause I drank that 409 right in front of my sister. I told her, ‘Don’t tell mom.’ That’s when it all began,” David explained. I was confused because of the details and severity of the
situation, especially the sex calls at nine years old and the beatings because he attempted to commit suicide. Furthermore, while it was the first time David tried to hurt himself, his struggles seem to arise earlier.

“You were ashamed that you made those phone calls,” I said.

“No,” David quickly replied before continuing, “I’m ashamed I drank that stuff. I shoulda’ admitted to it and took the beating. Try to maintain a life. I don’t know.”

“That first time you tried to kill yourself—you were afraid to tell your parents you did something that they wouldn’t approve of.”

“Yeah, kill myself, instead. I mean there’s other kids that do that. Not drink the 409 after they found out they were going to get in trouble though. I didn’t tell my mom. Yeah, I never told her I drank the coffee cup full of it. Didn’t notice nothing happened to me. It made my teeth pretty.” This seemed to contradict what he told me a few minutes earlier, regarding the punishment he received for drinking the 409. The details of the event are not as important as the ways David remembers events. *Throughout our interview, David’s memories seemed to be disconnected to him and this seemed to be experientially confusing to him, making it extremely difficult to verbalize these events.*

“And it didn’t hurt you?” I asked, confused. “No!” David loudly responded before continuing, “Right in front of my sister. Right on the carpet in the kitchen in our trailer. I mean just gulped it down. Yuck! Nasty taste. I don’t know if it was the chemicals in it that fucked me up or what? I dunno? Could of, couldn’t it?” David said, as he laughed a morbidly desperate laugh.

I shrugged my shoulders to convey that I did not have answer. “I don’t know either. You got any more questions just ask.”

“Seems like you’ve had a really rough life,” I said, a bit overwhelmed by his story. David softly responded, “Yes,” but had little else to say.

“It seems like you want attention now, but it seems like you feel you didn’t get it when” was all I could get out before David said, “Now I want the attention. I want to better myself, I do. I want outta here so bad. I don’t need to be here. I gotta get rid of the drinking. I know shouldn’t be taking other people’s meds…take Ephedrine and drink on top of that. But, there’s nothing wrong with taking a drink every once in a while. But, you shouldn’t drink on top of
medications, I know that. I don’t know if I should even be taking medication. That’s what I don’t know.” David said and punctuated his last statement with a sardonic laugh.

“You’re not sure if you should be taking medication? Seems like it feels like confusing inside.”

“Yeah. But, that’s why I said in the beginning, I’m gonna jump from here to there. I do,” David explained.

“What happens when you try to slow things down—talk and think slower—is it just hard to do that?”

“I could do that every once in a while. But, it’s very hard, you’re right, it’s very hard to do that—like think and slowly talk.” I began to say something, but David interrupted with a loud swishing sound. It is like a rollercoaster ride—like a circle…Ever since high school it has been like this. I can’t slow down and comprehend things. I graduated from high school barely by the skin of my ass. I tried the Navy, and that didn’t work out. I tried college and I partied too much—I kinda comprehended somethings. But, it was too fast for me. I had to have things slowly. Like I’m talking now. Try carry on a conversation with you, and I have to think slow. I can stay on the same subject now if you want. I mean things are flailing around too fast. If I wanna stay on a subject, I have to think real slow. I think slow [mimicking a slow motion scene with his hands and words]. And it’s still going on in my mind. I gotta think before I speak.” David’s inner life seemed terrifying, as his thoughts moved so quickly. While David tried, he could not slow down his thoughts, and, when he did, his mind continued to flail.

“Seems like it’s hard to,” I said, but David started, “It is hard…I mean I took Ritalin since the age of seven I think. Stopped when I went into boot camp, and then, when I went to some of these private hospitals, they put me back on Ritalin or other medications for ADHD, which they try an’ diagnose me with.” We were interrupted by a knock at the door, but when I sat back down, David began again, “Where were we? Oh, yeah. We were about, well, ADHD. See? I can slowly I can carry on a conversation when I talk slowly. I need something to control me slowly. I need that badly if I want to be productive in life. I wish the doctor could read this. I would love for a doctor to read this and make note of what I need and what I don’t need. They put so much crap in me, that’s off the subject, they put so much stuff in me, I can’t slowly comprehend my—I just talk off the wall. I have to slow down like this to carry on a conversation.”

“Have you ever talked about this stuff before?” I asked.
“No. ‘Cause I feel they don’t even listen. I mean, half this stuff I never tell the doctor. I told you everything that I never told the doctors. Tell them half of this stuff. And, I’d love to talk with the doctors, see what they think. And, you’re the only one, the very first one,” David said matter-of-factly.

“I guess I am surprised because you’ve mentioned being in a lot places like this and had a lot of therapists,” I said partly surprised, partly disbelieving that he did not talk about these issues with others.

“Yeah, I never talked like this before. I’ve told Will [his therapist] some of this stuff, he’s helped me out some, but I don’t know how to use the tools, to fight the system. You know?” David asked. I looked as though I did not and he explained, “Well I mean I know how to, but I don’t know if I need to use them or not. I mean, you fight the system, and you get institutionalized so long and you’re used to it, but, at the same time, you know you’re not used to it…I fought the system for too long to get attention, to do what I wanted sometimes. Couple of times I really needed to kill myself. That’s why I’m confused. But, look where all this brought me. Brought me here. To a state hospital. And, I can’t get out right now…but, I need the support. I mean I feel I should be somehow be able to get a job and I’ll keep it. I know I am going off the subject. They could keep me on the meds I need. Learn and comprehend things and slowly, you know, and keep focused and I can do it. I can do it. It’s all I need is those tools. I’ll do it. I’ll show people I’ve been a success, and I’m truly sorry for what I did to the system and I truly am. I feel like a piece of crap.”

David continued to describe how he did not want to be dependent on the system anymore. He exclaimed that he did not know what was wrong with him, other than his anger problems. When I asked him to describe his struggles with anger, he described how he cuts his arm, not only for attention, but to feel pain. I asked if he ever found himself violent when he was angry.

As David responded to my question, the rate of speech became even quicker, “Yes, I want to fuckin’ hurt ‘em. Don’t feel scared, but, I think I could pick up this chair and throw it at you. I think thoughts like that. It’s not right.”

“You have a thought that you want to throw your chair—”

“Yeah, just pops in my head. I feel that there are people that do that, just do things in the moment. Like I think of something to do right like rip this room apart. I think destructive thoughts. It’s ‘cause all my life is destructive, it’s destructive…I want outta here so I can show
the people that I don’t need this. This makes me mixed up in life. Confused. I don’t know what to do. I’m crying for help that someone tells me what’s wrong with me so I can go on.” David seemed to want others to believe that he could move on with the right kind of support.

“Sounds like you really want someone to come in and help you get things together.”

“Yes, I do. You know, I mean, you know, I could work myself out. I need some help. And I don’t want someone to do all the work and take over… I would work with them if they work for me.”

“It doesn’t seem to have helped in the past,” I stated.

“No. The things that’s been done hasn’t helped,” David said and stopped for the longest time in our conversation.

I changed topics and asked him about his stepfather. “Oh. He came into my life at the age of six. He abused my mother and a couple times threw chairs and took her into walls. Um, I swear he cheated on my mother. I don’t know if he I don’t know if he did or not but I have a feeling he did. And, they’ve been married for like 20 some odd years. I just have a feeling he did it. He tried to he tried to make a life with me but I chose not to take it. Didn’t. Remember one time I was in my room. And, he came in and, I don’t know he was going somewhere, and we drove to the college, with a student that looked exactly like you for some reason like in the early 90 or mid 80s. A kid was selling tickets. He came up and my step dad asked him how much they were. The kid said, ‘I want $100 some odd dollars.’ And my step dad goes, “Oh that’s too much.” And I think I had my head down, I was just happy enough to be on the campus. And he turned around and he bought them. I love him for that. I don’t like the other stuff he done—there are two, no three, great things we ever had done—I’m off the subject again. See? See that?” I did not agree that David was off-track. Instead, I thought he had difficulty understanding his stepfather’s disparate actions. On the one hand, he shared some good memories with his stepfather and experienced him as a caring person (e.g., buying expensive tickets so David would not be upset, taking him to a football game). On the other hand, this same person would be violent and unpredictable and often violate other’s privacy (e.g., throw his mother into a wall, make David and his sister take showers with him).

“You were able to spend some time with your Dad—” I said, but David interrupted me to correct me. “My step-dad. I was forced to call him dad. I mean, I’ll cherish those moments.
And I’ll always remember the negative, too. I still feel negative about my mother. But, I think counseling would help.”

“Have you spoke with your mother and stepfather about some of these things we’ve talked about?” I asked.

“No! Heck no! It would be great if I could,” David exclaimed.

“Why do you say it that way?”

“I don’t tell ‘em all this stuff! Oh, that would that would probably turn into a brawl in there. No I mean, it’d be like the Jerry Springer show in there, man. It would. Make the Jerry Springer show like look like the Maury show.”

“It seems like it would be difficult to carry all this around alone. Do you have anyone you would consider a friend?”

“No, ‘cause I’m always negative. I feel low…right here me with is the lord. Well he’s not—he’s here inside me—he’s been in here with us…I’m trying to be a very religious person, ok? I wanna be religious. I wanna be a godly person, but I can’t do it every day. I just don’t wanna burn in hell. I don’t. It’s forever.”

“It seems like it is hard to forgive yourself,” I reflected.

“Yes, I forgive myself, I have to. But, it’s just that thought in my head, ‘You’re gonna burn in hell. You’re gonna burn in hell.’” David quickly changed topics and said, “All the students will hear this tape? That’s cool.”

“You like the idea of—” I said. David responded, “I want them to hear everything. Hear what someone like me has been through. I want ‘em to I want them to have to think real hard. I’m serious.”

“Tell me about that.”

“I want them to see if they can, what they can come up with. I mean that’d be interesting. I bet all these students that hear this I mean—everyone is gonna come up with a different ones and some will come up with the same. And, there’s no way you can all come up with the same one. What’s the odds of you all coming up with the same with the exact same one? What’s the odds of that?” David asked. I explained what the diagnosis group would do. He asked a few more questions about the group and liked the idea of everyone contributing something. When I said the group would come up with two different diagnoses, he responded, “Everyone could add their piece. Like a, like a debate. Or, not a debate, but a jury, like a jury trial. Where they come
in and they decide like the decide who to punish. I would like to be there, but it would be boring for me.” I was surprised that David saw us as a jury. He seemed to expect a sentence or verdict from us. I told him that while he could not be there, he would receive our ideas. David assured me that he was being honest and I asked him what it was like to talk about himself this way.

“Feels good. It does. You know, you saw me when I first came in. What was the look on my face? Tell me.”

“You didn’t seem like you really wanted to talk,” I offered.

“Yes! No one’s ever gave me the time like you. But, everything looks like blurry right now. I’m lookin’ at you. Bottom part of your face is plain, and, this, right here [points to the top and middle of my face], is blurry. It’s like I don’t know what it’s wrong with me. I mean, I’m off the subject again. I’m sorry. I mean I’m doing that with everyone I talk to for some reason. But, everything’s coming clear when I talk to you. And I tell you how I feel. I can—for some reason and don’t be offended, Will, but I connect to you. I feel relieved telling you. I don’t mean to use you as a bitch—I mean [his words were muffled by giggling and laughter]. Sorry, but I mean, as a father, a Catholic priest, I confided in you. I can trust Will but I wouldn’t—I mean you gotta trust other people, right? So, I trusted you, and I confided in you.” While it made me happy that David could trust me, it seemed that in trusting me, I became less of a person. My face became blurry; I was objectified and a “bitch.”

“Well, I guess my question is, what about sitting down with me, makes you trust me? ‘Cause you’ve known Will for few months now.”

“Yeah. And, it’s something I felt. I can’t describe how I felt easily. But it seems like you’re interested in knowing what’s going on in me.”

“Trust is important—” I started. David interrupted with “So, I can that I can learn what I missed in life.”

“It seems like the people you trusted ended up hurting you,” I observed.

“Yes! I mess up and do the things again. You know, I mess up and do what I do.”

“Do you do avoid trusting people?” I asked.

“I avoid. I try to tell them how I feel and they don’t—can’t comprehend. But, I get pissed off even when they do. I still get pissed off. It’s weird,” David said and laughed at his final statement. His calling me a bitch made some sense in this context. Possibly, someone understanding was so threatening to David that he became angry.
“So, even when you can trust someone, you find yourself getting angry at them,” I reflected.

“Yes. Sometimes I do,” David said. His next few words were muffled by his laughter. “One time I was in a class and wanted to hit a kid while the fucking teacher was sitting right next to him. I’m serious. I felt like grabbin’ him and beating the shit outta’ him. Now that’s not right. I gotta come to reality, man. All hell’s gonna break loose. You know? It’s like I gotta tell myself why I gotta do, I gotta write it down, or say it to someone, but I’m not gonna do it…There have been a couple times I did do whatever came to mind, and then all hell did break loose! And, I paid for the consequences. Not one time in here I felt like doing any of those things. I just, I laid it all on the line. Like you’re a cop, and I had to be interrogated. I know you’re not a cop, but still, I laid it laid it all out. Had to let it out. And just be balled up all these times, not once to have it balled up inside. I feel relieved. I do. Man, it’s better than sex, man.”

We spent the last few minutes of our time together discussing the importance of discussing one’s inner experience. David lamented that he did not have enough time to talk with the psychiatrists, but reiterated that he wanted to figure out if he was mentally ill and get on with his life to prove to everyone that he could. We made plans to meet after dinner and medication, but I will not describe this interview in detail for the reasons provided earlier.

After dinner, we met for about an hour and a half, focusing on David’s destructive behaviors. David described more suicide attempts, detailed fantasies and plans of killing his parents as a teenager, urinating in food as a waiter, abusing his wives, and knowingly spreading herpes to others. David reported that both of his marriages were very short. In both cases, he cites sex as the major reason he became involved with these women. His first marriage ended when he ran away after physically assaulting his wife while drunk. His second marriage seemed to be worse than the first in that he was abusive for the duration of the marriage. He also said that he felt controlled by his second wife and often cheated on her with other people.

**Preparation of Experiential Constructivist Diagnosis.** In this section, I will be providing the diagnosis I presented to David juxtaposed with a description of how we constructed the EPCP diagnosis. Throughout the diagnosis, the research group gave David some examples that provided a basis for our decisions about his experiential constructivist diagnosis. However, the research group used many more examples of his struggles than we could provide in a summary. On axis I, we concluded that David struggled with self-other permanence and had a very fluid
understanding of self and other. Out of the four participants, David seemed to have the most
difficulty with self-other permanence, as he did not seem to have a sense of self-other
permanence any time. We focused on David’s struggles with self-other permanence in relation
to structural arrests, the symptoms he described, his recurrent attempts to kill himself and his
destructive behavior. On axis II, we concluded that David avoided dependencies altogether and
described the ways he psychologically and physically distanced himself from other. On axis III,
we concluded that David struggled with discrimination (both over- and under-), commitment,
openness and responsibility. While David struggled with other concepts of axis III, we decided
to be concise and describe only these concepts, as they were representative of his struggles with
the experiential components.

Because David struggles primarily on axis I, we began the diagnosis with a description of
how his struggles with self and other arose:

The intense struggles you have described in defining who you are may be understood in
relation to frequent injuries you experienced at an early age. These injuries affect your
struggle to form a solid and stable sense of self—a self that you could use to engage
others and the world. For all of us, early understandings of the self are fragile and
delicate. However, with reliable and consistent nurturing, these understandings become
more solid and stable. Unfortunately, those people closest to you early in life came and
went in unpredictable ways, making it difficult for you to develop a self that feels
permanent and consistent.

We then discussed the father figures in his life to provide an example of the difficulties
he had in constructing a consistent sense of self and other.

One example of this struggle is the way you describe your biological father. Your
parents’ divorce and his leaving your life seem to have affected you in profound ways.
The troubles in your biological parents’ marriage may have affected you before your
father left you at the age of three. As we cannot take care of ourselves during the first few
years of life, we require support and care from our parents. When parents become
preoccupied with other things, it often leads to some amount of neglect. It is likely that
the troubles that lead to your parents’ divorce made it difficult for you to come to solid
understandings of yourself and others. Your mother’s remarriage did not seem to help, as
your stepfather was often emotionally, physically and sexually abusive to you, your
mother and your sister. These early injuries that came in the form of abuse seem to have affected your ability to feel stable and secure, which also makes it difficult to have relationships with others currently. For example, you described that, at certain times, you feel as though you are not yourself.

His biological father’s departure affected David in profound ways and left him feeling unworthy. As his stepfather was emotionally, physically and sexually abusive to him, David had difficulty feeling both worthy and unworthy of love. Put differently, if David had a more solid sense of self and other, he would be able to feel worthy of love and attention, as he may have not hurt others so profoundly. Thus, David felt like a completely different and evil person. We concluded this section by describing the difficulties most children have in constructing a solid construction of self and other in the face of abuse:

- It is difficult for children to make sense of abuse, as it is difficult for children to understand why the abuse is taking place. This often leads to children taking responsibility for the abuse by thinking they were the cause of it. This may lead to children feeling as though they are bad and unworthy of the attention and love of others.

We wanted to make it clear that David’s sense of self and others often felt fluid and it was often difficult to make sense of one’s responsibility in a given situation.

The next section focused on David struggles with self-other permanence in the present. We described the shifts in his sense of self, which left him feeling like two different persons.

These struggles seem to affect you currently. At certain times, you see yourself as open, accepting and caring. At these times, it seems as though you understand that you deserve attention and love from others. You mentioned that you were a good kid and this may come from this part of yourself. At other times, you seem to shift to seeing yourself as angry, destructive and evil. At these times, others may seem dangerous and, in order to control being hurt by them, you may treat them as ways to get what you want. An example of this is your description of the way you feel towards your father now. On the one hand, when you see yourself as caring and deserving of attention, you describe really wanting to see him and have him accept you. It seems as though your father not taking the initiative to see you, as you deserve someone’s love and attention, confuses you. On the other hand, you are angry with him and want to get him back for what he did to you. At these times, he seems dangerous, as he has the ability to leave you again. You describe
using him for money and material goods at this time and this may be a way for you to protect yourself from getting hurt again. Shifting between these two perspectives, from accepting and deserving to angry and destructive, makes it difficult to maintain relationships because you may feel confused about your own feelings and the feelings and behaviors of others.

We provided another example of how these shifts in perspective manifested in his relationship with his mother:

Another example of this shift in your sense of who you are may be your description of calling your mother names and then feeling guilty or confused about why you would do such a thing. It seems as though you feel she should have supported you more and are angry that this did not take place. Thus, you deserved to be supported and accepted by your mother and, when she did not support you in the ways that felt correct for you, you became upset and angry, which may have lead to calling her names.

We wanted to describe how it was difficult for David to express anger and emotions generally. We connected his difficulty expressing his emotions to early structural arrests, providing an example of how not having a solid sense of self and other made it difficult to be in relationships.

We continued by describing how it was difficult for David to feel a stable base or foundation:

You seem to have trouble trusting your emotions and using them to have relationships with others. As a child, you may have felt ashamed of your thoughts and emotions. You describe your mother forcing you to answer the question, “Who do you think you are?” with “No one,” and not allowing you to use your name. It seems as though you were not allowed to exist at these moments, which would make it difficult to accept your other thoughts and emotions.

We continued by describing David’s frequent attempts to kill himself as a manifestation of struggles with permanence:

These shifts in your understanding of who you are along with these feelings of shame may help you to understand your recurrent thought that you are going to hell. It seems as though you feel you need to be punished for thoughts and behaviors. This may also help you understand your thoughts about suicide. It seems as though you become afraid of punishment and rejection by others that suicide seems like the only possibility. At these
times, it may be useful for you to try and feel those parts of yourself that deserve acceptance and caring from others.

David often felt his actions were evil and often had the thought “I am going to hell” repeating over and over again in his mind. David seemed to punish himself when he felt evil and his suicide attempts seemed consistent with these feelings.

We then turned to axis II and described how it often felt difficult for David to trust others enough to enter into a relationship with them:

Due to these struggles with defining yourself in relation to others, it seems difficult for you to depend upon others. Because you were not able to reliably depend upon your parents, it is difficult for you to put yourself in a position to depend on others. Relationships can be awe-inspiring experiences, as others can confirm us in profound ways. At the same time, relationships can be terrifying, as others have the ability to reject and invalidate us as they become closer to us. It seems as though you avoid being dependent on others and find ways to distance yourself from others.

We then described the ways David psychologically distanced himself from others:

For example, you mentioned using people for sex and entering into relationships for sex. While sex is an important part of relationship, seeing others only as sexual partners does not allow us to fully enter into a relationship with them.

You also mentioned abusing your wives, which may have been a way for you to distance yourself from the relationship and cause it to end. Having others become close to you may be a frightening experience. Given all the chaos in your early relationships, it seems reasonable that you would find it difficult to depend on others.

We moved to describing his struggles with axis III. We described his struggles with over- and under- discrimination, commitment, openness and responsibility:

All relationships have the potential to injure us. Discriminating between those where the risk of injury is too high versus those where the risk feels more acceptable can be a struggle. It seems as though it is difficult for you to become emotionally involved with others, which leads you to finding reasons not to become closer to another person. At other times, it seems that you would enter into sexual relationships without the same concerns. In either situation, it was difficult for you to enter fully into a relationship with another person.
Committing to another person in a relationship also seems to be difficult. You described having very short marriages. Knowing if we can exist with another in relationship takes time, as we cannot figure out if another can support us (and if we can support them) in ways that feel correct in such a short period of time. As mentioned above, you described physically abusing your wives, which may have been a way for you to end the relationship without actually having to end it. In other words, your actions caused your ex-wives to end their relationship with you.

Understanding how past injuries affect you currently may be an important part of understanding who you are presently. When psychological injuries occur in past relationships, it becomes difficult to leave these injuries in the past. Understanding new relationships in terms of old relationships is useful, but we often can bring the hurt from past relationships into our current ones.

Negotiating the tension between feeling responsible for who you are presently and understanding how those past injuries affect you presently may allow you to feel more stable and connect to those parts of you that are caring and deserve attention and love. This may help you feel more stable in relationships.

We wanted to underscore the importance of David recognizing past struggles in the current context and provide some way for David to make sense of existing in relationships.

While I have provided the entire description of the diagnosis that I presented to David, I will provide the unbroken description to facilitate comparison of the two diagnoses for the reader. I provided the following description to David:

The intense struggles you have described in defining who you are may be understood in relation to frequent injuries you experienced at an early age. These injuries affect your struggle to form a solid and stable sense of self—a self that you could use to engage others and the world. For all of us, early understandings of the self are fragile and delicate. However, with reliable and consistent nurturing, these understandings become more solid and stable. Unfortunately, those people closest to you early in life came and went in unpredictable ways, making it difficult for you to develop a self that feels permanent and consistent.

One example of this struggle is the way you describe your biological father. Your parents’ divorce and his leaving your life seem to have affected you in profound ways.
The troubles in your biological parents’ marriage may have affected you before your father left you at the age of three. As we cannot take care of ourselves during the first few years of life, we require support and care from our parents. When parents become preoccupied with other things, it often leads to some amount of neglect. It is likely that the troubles that lead to your parents’ divorce made it difficult for you to come to solid understandings of yourself and others. Your mother’s remarriage did not seem to help, as your stepfather was often emotionally, physically and sexually abusive to you, your mother and your sister. These early injuries that came in the form of abuse seem to have affected your ability to feel stable and secure, which also makes it difficult to have relationships with others currently. For example, you described that, at certain times, you feel as though you are not yourself.

It is difficult for children to make sense of abuse, as it is difficult for children to understand why the abuse is taking place. This often leads to children taking responsibility for the abuse by thinking they were the cause of it. This may lead to children feeling as though they are bad and unworthy of the attention and love of others.

These struggles seem to affect you currently. At certain times, you see yourself as open, accepting and caring. At these times, it seems as though you understand that you deserve attention and love from others. You mentioned that you were a good kid and this may come from this part of yourself. At other times, you seem to shift to seeing yourself as angry, destructive and evil. At these times, others may seem dangerous and, in order to control being hurt by them, you may treat them as ways to get what you want. An example of this is your description of the way you feel towards your father now. On the one hand, when you see yourself as caring and deserving of attention, you describe really wanting to see him and have him accept you. It seems as though your father not taking the initiative to see you, as you deserve someone’s love and attention, confuses you. On the other hand, you are angry with him and want to get him back for what he did to you. At these times, he seems dangerous, as he has the ability to leave you again. You describe using him for money and material goods at this time and this may be a way for you to protect yourself from getting hurt again. Shifting between these two perspectives, from accepting and deserving to angry and destructive, makes it difficult to maintain
relationships because you may feel confused about your own feelings and the feelings and behaviors of others.

Another example of this shift in your sense of who you are may be your description of calling your mother names and then feeling guilty or confused about why you would do such a thing. It seems as though you feel she should have supported you more and are angry that this did not take place. Thus, you deserved to be supported and accepted by your mother and, when she did not support you in the ways that felt correct for you, you became upset and angry, which may have lead to calling her names.

You seem to have trouble trusting your emotions and using them to have relationships with others. As a child, you may have felt ashamed of your thoughts and emotions. You describe your mother forcing you to answer the question, “Who do you think you are?” with “No one,” and not allowing you to use your name. It seems as though you were not allowed to exist at these moments, which would make it difficult to accept your other thoughts and emotions.

These shifts in your understanding of who you are along with these feelings of shame may help you to understand your recurrent thought that you are going to hell. It seems as though you feel you need to be punished for thoughts and behaviors. This may also help you understand your thoughts about suicide. It seems as though you become afraid of punishment and rejection by others that suicide seems like the only possibility. At these times, it may be useful for you to try and feel those parts of yourself that deserve acceptance and caring from others.

Due to these struggles with defining yourself in relation to others, it seems difficult for you to depend upon others. Because you were not able to reliably depend upon your parents, it is difficult for you to put yourself in a position to depend on others. Relationships can be awe-inspiring experiences, as others can confirm us in profound ways. At the same time, relationships can be terrifying, as others have the ability to reject and invalidate us as they become closer to us. It seems as though you avoid being dependent on others and find ways to distance yourself from others.

For example, you mentioned using people for sex and entering into relationships for sex. While sex is an important part of relationship, seeing others only as sexual partners does not allow us to fully enter into a relationship with them.
You also mentioned abusing your wives, which may have been a way for you to distance yourself from the relationship and cause it to end. Having others become close to you may be a frightening experience. Given all the chaos in your early relationships, it seems reasonable that you would find it difficult to depend on others.

All relationships have the potential to injure us. Discriminating between those where the risk of injury is too high versus those where the risk feels more acceptable can be a struggle. It seems as though it is difficult for you to become emotionally involved with others, which leads you to finding reasons not to become closer to another person. At other times, it seems that you would enter into sexual relationships without the same concerns. In either situation, it was difficult for you to enter fully into a relationship with another person.

Committing to another person in a relationship also seems to be difficult. You described having very short marriages. Knowing if we can exist with another in relationship takes time, as we cannot figure out if another can support us (and if we can support them) in ways that feel correct in such a short period of time. As mentioned above, you described physically abusing your wives, which may have been a way for you to end the relationship without actually having to end it. In other words, your actions caused your ex-wives to end their relationship with you.

Understanding how past injuries affect you currently may be an important part of understanding who you are presently. When psychological injuries occur in past relationships, it becomes difficult to leave these injuries in the past. Understanding new relationships in terms of old relationships is useful, but we often can bring the hurt from past relationships into our current ones.

Negotiating the tension between feeling responsible for who you are presently and understanding how those past injuries affect you presently may allow you to feel more stable and connect to those parts of you that are caring and deserve attention and love. This may help you feel more stable in relationships.

*Validation of the DSM Diagnosis.* David was diagnosed with schizoaffective disorder. We used much of the language of the DSM and did not change very much, other than explaining some of the language. I will describe how David met criteria for schizoaffective disorder and provide the description I presented to David. We believed that the specifier bipolar type was
more accurate than the specifier depressive type. However, we did not use either specifier as none was indicated in his chart.

One must meet the following four criteria to be given a diagnosis of schizoaffective disorder. First, one must experience at least two of the following symptoms for most of a one-month period: delusions, hallucinations, disorganized speech, grossly disorganized behavior and negative symptoms. From our interview, David’s speech could be considered disorganized and his behavior could be called grossly disorganized. His inability to see my face clearly at some points could be considered a hallucination. From the report of others at the hospital, David experienced hallucinations upon intake. Second, one must experience hallucinations and delusions for at least two weeks in the absence of predominant mood symptoms. We could not confirm this criterion from the interview. Third, symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of illness. From our interview, it seemed that David would have met criteria for bipolar disorder. Lastly, the disturbance must not be due to the direct physiological effects of a substance or a general medical condition. We assumed that David was not using substances regularly while in the hospital and hospital staff upon intake ruled out a general medical condition.

I presented the following description of schizoaffective disorder to David:

Individuals with struggles similar to yours are characterized in the following fashion. The essential feature of such struggles is a不间断 period of illness during which, at some time, there is a depressive and/or manic episode along with another set of symptoms that involve a range of cognitive and emotional dysfunctions. These cognitive and emotional dysfunctions include perception, thinking, language and communication, behavioral monitoring, affect (emotions), the ability to experience pleasure, motivation, choice and attention. These terms will be further defined below. Thus, such struggles may be understood as made up of two sets of symptoms (depressive/manic symptoms and cognitive and emotional dysfunctions) that appear simultaneously as well as separately.

These symptoms may be conceptualized as falling into two broad categories: positive and negative. The positive symptoms appear to reflect an excess or distortion of normal functions and include distortion in thought content (delusions), perception (hallucinations), language and thought process (speech and thoughts that are not
organized coherently), and self-monitoring of behavior (disorganized or catatonic behavior). For example, individuals with such struggles may find it difficult to communicate effectively with others or may behave in ways that others have difficulty understanding. These positive symptoms may comprise two distinct dimensions. The first dimension includes delusions and hallucinations, whereas the second dimension includes disorganized speech and behavior. Negative symptoms include restrictions in the range and intensity of emotional expression, in the fluency and productivity of thought and speech, and in the initiation of goal-directed behavior. An example of a negative symptom is facial expressions that do not show inner emotion. Another may be speaking very little to others.

Delusions are erroneous beliefs that usually involve a misinterpretation of perception or experiences. For example, one may believe that they are being punished or persecuted in the absence of someone punishing them. The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear contradictory evidence regarding its accuracy or truth. Although bizarre delusions are considered to be especially characteristic of such struggles, “bizarreness” may be difficult to judge, especially across different cultures. Delusions are deemed bizarre if they are clearly implausible and not understandable to others and do not derive from ordinary life experiences.

Hallucinations may be auditory, visual, olfactory, gustatory and tactile, but auditory hallucinations are by far the most common. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person’s own thoughts. Hallucinations may be a normal part of religious experience in certain cultural contexts.

The speech of the individuals with such struggles may be disorganized in a variety of ways. The person may “slip off the track” from one topic to another; answers to questions may be loosely related or completely unrelated; and, rarely, speech may be so severely disorganized that it is incoherent. The symptom must be severe enough to substantially impair effective communication.

Grossly disorganized behavior may manifest itself in a variety of ways, ranging from childlike silliness to unpredictable agitation. Problems may be noted in any form of
goal-directed behavior, leading to difficulties in performing activities of daily living such as preparing a meal or maintaining hygiene. The person may appear markedly disheveled, dress in an unusual manner, display clearly inappropriate sexual behavior or display unpredictable and untriggered agitation. For example, one may suddenly act aggressively and attack someone without being provoked.

The negative symptoms associated with such struggles include affective flattening, alogia and avolition. Affective flattening is especially common and is characterized by the person’s face appearing immobile and unresponsive, with poor eye contact and reduced body language. Alogia (poverty of speech) is manifested by brief, empty replies. Avolition is characterized by an inability to initiate and persist in goal-directed activities. The person may sit for long periods of time and show little interest in participating in work or social activities.

The symptoms of such struggles may occur in a variety of patterns. The following is a typical pattern. An individual may have pronounced auditory hallucinations and delusions that they are being persecuted for two months before a period of feeling manic. The manic feelings and auditory hallucinations are then present for three months. Then, the person recovers completely from the manic symptoms, but the hallucinations remain for another month before they too disappear.

There may be poor occupational functioning, a restricted range of social contact, difficulties with self-care, and increased risk of suicide associated with such struggles. Poor insight is also common in such struggles. The use of alcohol or other substances is also common.

The typical age at onset of such struggles is early adulthood, although onset can occur anywhere from adolescence to late in life. The prognosis of such struggles tends to be mixed. In other words, it appears that symptoms rarely fully disappear, but some individuals’ symptoms may decrease with time. The presence of precipitating events or stressors is associated with a better prognosis or outcome. There is substantial evidence that there is an increased risk for such struggles in when direct relatives also have similar struggles.

*Presentation of the Experiential Constructivist Diagnosis.* Unfortunately, I neglected to ask David my first framing question regarding his personal theory of psychological struggles.
Because we only had a short time to finish the interview, I was a bit too hasty and did not realize my error until he was well into the experiential constructivist diagnosis. I began by explaining what we would be doing to David, and, after he exclaimed, “This is going to be interesting!” asked if he could read the diagnosis aloud. I agreed, as I could make sure David understood what we had written.

Instead of including David’s reading of the diagnosis, I will provide all of the times David stopped to comment on the diagnosis itself. David validated the notion that his parent’s divorce and his father’s flight from the family affected his present life. He also validated our description of the way he shifts from seeing himself as deserving of love and attention to seeing himself as angry, deceitful and evil. After reading the section describing his objectification of others (i.e., others feeling too dangerous and, thus, using them as a way to control being hurt), he said that it was true and paused as if it was a new way of seeing himself. He validated the entire diagnosis (“you’re doing good, you got it good so far”) as he was reading the section describing his anger and the ensuing confusion regarding his feelings towards his mother. When he read how his mother made it hard too feel permanent by telling David to respond “no one” to the question “who do you think you are?” David exclaimed, “I didn’t exist.” The connection of his suicide attempts and his need to punish himself seemed to impact him and he made a sound (Ohh!) as he read this part. Lastly, he validated the section regarding his abuse of his ex-wives and his difficulties with commitment and ending a relationship. Our description of his trouble with commitment gave him pause, as he said this was an interesting way to see it.

After he read the diagnosis, David said, “That’s very beautiful. I mean, maybe not beautiful, that was very concrete, you know. I mean the situation that you talked about how, um, about how some people can hurt me and risking… I don’t want to turn this into a therapy session, but I mean I am in that kind of predicament now with a girl that I like. And, it’s confusing, like you said in there, and you said I’m confused sometimes. Well, I am. Hell, I’m always confused! But in that predicament, I just have to let myself out. Remember when I said that last time I saw you, I said I might as well live on my own. To have goals and my life. I still want to use drugs and alcohol, and hell, I mean, I planned—thought about saving money sometime next month. And, at nighttime, when we go outside, walk off grounds and go to that bar and start slamming down beers and shots. And just say to hell with it. Now, I ain’t gonna do it, but you know, I want to, but, now what theory did you come up with for that?” I found it interesting that David
found the diagnosis both beautiful and concrete. David seemed to say that the diagnosis was useful as he was able to use it to understand his current predicament with a woman. *His comments about having goals and going back to drinking seemed unrelated at this point, but made more sense as the interview continued.*

I told him I would prefer to talk about the diagnoses before telling him how we came up with them and asked about his initial impressions of the diagnosis. David responded, “It basically describes what I wanted to talk about the last time I saw you. I mean I can’t wait to see what the other one says, but, this one basically describes my whole life. It’s like a book…it’s like having it all one place.” David saw this diagnosis as a summary of our last conversation, *but, from the rest of the interview, it seemed as though this was not the case.*

“Did it feel right for you?” I asked.

“Yeah, about my memories. Of our last talk, that is correct. I’m surprised you—I’m glad you could do that. I mean, I mean it’s very interesting and very—I dunno, I’m, [David stopped and started a thought a few times here]. Hell, it’s like I don’t know what I’m trying to say, but it’s very interesting that someone like that could do about me on paper. I couldn’t even do that. I commend you for that,” David responded as he shook my hand. I thanked him and again he said I was very good. I nervously laughed at this point, having difficulty accepting his praise.

He was aware of my discomfort and responded, “I just want to give you some praise—love—it’s very good.” *David seemed much more coherent in contrast to our first meeting. I wondered if the diagnosis helped him feel more stable and solid.*

I recovered and said, “It sounds like it feels good for someone else to say that back to you and be able to understand you.” In our first interview, David had trouble understanding why he struggled, and I understood his last comments within this context. He validated my understanding and asked what would happen to the diagnosis after we were done with our meeting. When I told him that I would keep it and use it to write up my project, he seemed disappointed that others would not get to see it. Often, David openly wished that the doctors could listen to our conversation, so they could understand him better. His disappointment may have stemmed from his desire to share the diagnosis with others at the hospital.

David quickly changed topics and focused on the diagnosis once again. He began, “About the parents and me being—how it affected me emot—it did affect me, still affects me to this day. And, I still use I still want to use my parents. My mom was slowly deteriorating with
scoliosis, deteriorating bones in her neck and carpal tunnel. She works in the factory, and she’s 51 years old. I do commend her for it, and I do think that I should make up with her before she dies. But, I’m gonna make up with her. And, then, I have two other relatives: my dad and step dad. But, I gotta make right with my mother. I tell you I’m gonna. These are my goals that I came up with since the last time we met. Move to a city. I’m talking with the organization, go to a group home, get a job coach, get an apartment and I’m gonna go to art school. And, I’m first of all I’m gonna get a job at a fancy restaurant, at a nice restaurant downtown—be a waiter. I hope they will let me be one. Are there guy waiters?” I assured him that there were, even though I was surprised David needed to ask.

He continued, “Then I could get a job at a hospital. There’s plenty of hospitals down there or do house work or housekeeping. And, go to school part time. And, get an art degree and then get a social work degree. There’s gotta be a four year college down there. Get a social work degree work at a hospital doing art therapy and social work.”

“Oh, okay, that sounds good,” I was a bit confused by the way this would occur.

“That’s my dream. But, I still want to use—I just wanna live here! Part of me wants to live in this building for life! I’m confused by these thoughts. Those thoughts are running through my mind,” David explained. David’s ambivalence was conveyed in the close juxtaposition of wanting to leave and wanting to stay in the hospital.

I reflected, “It seems that you are confused on the one hand by wanting to get out and, on the other, wanting to stay.”

“Yes. I mean, I have to kick myself in the ass so much everyday. I just want to sleep. I mean I don’t want to try and use this as a therapy session, I am just trying to express my thoughts.”

“Sure.”

“These events that go through my mind everyday. This is what’s been on my mind since the last time I saw you.”

I referenced the diagnosis and said, “Seems like you’ve been describing some of the stuff I wrote up in there. For example, on the one hand, you see yourself as wanting to be here, you want to use. You say to yourself ‘I’d rather just be here.’ On the other, you see yourself as being able to fulfill the goals you just listed.”
“And, I know, I got to keep doing that. I told you I’m using the system. I mean I want to be outta here, I do. I mean I don’t know if I have a mental illness. We’re bound out to find out today?”

“Well, I don’t know if we’ll find out, but we’ll talk about it. We can talk about that more when we are done.” David seemed content with my response and asked when our third session will be. When I informed that we probably could not meet for a third time, he seemed disappointed, but recovered quickly and focused on the diagnosis, almost in an attempt to stay on track. He asked if he could look over the diagnosis again and began to read aloud and comment on the diagnosis. “I couldn’t take care of myself during the first few years of my life. Yes, I did require support from my parents, but I didn’t get it, really. That’s basically what I told you, that’s true. This paper I mean I mean it’s very—if I were your professor, I’d give you 100.”

I thanked him, but was unsure of how to take his flattery, as he would praise me but not offer any substantial comments on the diagnosis. *I wondered if he was trying to manipulate me as he did with others.* He commented that he would like to meet my thesis advisor and lamented that he could not. Again, he mentioned that the way we described his struggles was very interesting. The conversation, at this point, changed topics a few times within a few minutes. He first mentioned that he began to miss his therapist who had just finished his internship at the hospital. He then asked what his old therapist could do with his degree, which led David to asking me about my academic path. He then asked me a few questions about his plans to be a social worker that I could not answer adequately. David seemed to want to use his experience to help others. He said, “Well, I want, like I told you, I want to help people. I want to help people ‘cause they can relate to me almost. I mean I don’t know what’s wrong with me but these things, I don’t know but I want to be able to help people. To get into their minds—I mean I’m not going to be Dr. Hannibal Lecter. I mean I’m not going to eat the guy’s brain, while he’s awake and talk to him. I just want to get into people’s minds like you guys are. To help them.” I found it interesting that there was a fine line between empathy and consuming another’s brain. We spoke for a few more moments about David’s artistic pursuits, mainly drawing and writing poetry. David showed me some drawings that he had with him that were exceptional.

I returned to my questions and asked how the diagnosis described his strengths and weaknesses. David said that he had a lot of weaknesses, but seemed to realize that I did not ask him about how he saw himself but rather how the diagnosis described him. He asked to read the
diagnosis again. He seemed flustered that he could not remember details and assured me that he understood it. I let him know that it was perfectly fine to refer to the diagnosis, as he had no way of knowing what I would be asking.

“It mentioned that I was a good kid and you said this may come from this part of yourself. I was a good kid, I think, yes I was. I was trying to be perfect and do what they want me to do. I didn’t say what I wanted to do. Basically, I give them my life and let them live my life,” David suddenly stopped and apologized for getting off-track. He looked over the diagnosis for a few moments and said, “Well, I don’t know if this would be a good thought, but [reads part of diagnosis] this may help you understand your recurrent thought about going to hell—well that wouldn’t be a good thought about me. Basically, what I’m thinking the good thoughts are, the ones that are negative thoughts that I think are good for me is what I’m feeling inside. If I am feeling the opposite.” I was a bit confused at this point and attempted to summarize what he was communicating to me.

“So, you feel like the negative thoughts are good for you.”

“Yeah,” David responded. I asked him to elaborate. “So, you said, I felt unloved and even thought I was a good kid. I felt unloved and neglected and ashamed ‘cause I had to say when my mom would say, ‘Who do you think you are?’ And I had to say, ‘No one.’ That’s better than I could even think…my good thoughts are my negative ones. That’s what I’m thinkin’. I think that the good thoughts, one good thought that I can see so far is that when you mention that you were a good kid, which I was, even though I still felt the negative thoughts or feeling good thoughts which is confusing me.” While confusing at the time, it appeared that David was communicating that the tension between being a “good kid” and an evil person worthy of punishment was a strength. Possibly, it helped David see these two parts of himself for the first time. This was the first time in our conversation these two parts of David seemed to be in communication as opposed to two fragmented parts. In our earlier conversation, it appeared as though David could not communicate that he was a good kid “even though” he had negative thoughts.

“It seems like the negative ones feel more familiar. You are used to the negative ones,” I offered.

“Yes,” David quickly responded. I was not sure if he had nothing more to say or if I did not ask my question appropriately. I rephrased my question and received the same answer.
“And, they are a little harder to think about,” I offered.

David responded, “How can you think positive when you think negative all the time? I gotta learn to do that, you know? Well—I felt—I don’t know—I’m going to put it [the diagnosis] down for bit.” David then asked me how well I knew his previous therapist. I told him that I knew him from working with him for the last six or seven months.

“You know, one thing that I didn’t like about him, I liked his stuff a lot, but one thing I didn’t like about him was one day I wanted to talk about my past to get it out of my head. He just made me stick it back in my head. No! I went to put it on the table so I can let it go. I can’t put it back in my memory and just not think about it no more. If I get it out my mouth, I don’t think about it.” I knew very little of his work with his therapist but chose to believe his words. While discussing his past was important to David in order to find some peace with his past injuries, he felt his therapist did not want to discuss or process these events with him.

“So, you wanted to talk about your past—put it out there,” I reflected. “Lay it on the table,” David interrupted. “So you weren’t talking about some of these things with Will?” I asked.

“Yeah, you know, I want to talk about the future and DBT. Yes. And he worked with me, yes. He gave me positive thoughts and things. But, I didn’t like that all the time. I liked him and didn’t like him. With you, I do like it ‘cause this is helping me, but still when I go to my new therapist, I am going to have to talk about my past again ‘cause I want to tell her, so she can help me. Especially ‘cause I won’t be seeing you no more. You have helped me, I am telling you the truth. I’ve told Will he has helped me, but talking to you has helped me also. I have to get it out of my head. I say what I want to do, but I don’t do it. Did I tell you that?”

While he was referring to me, he seemed to validate the way the diagnosis discussed his past. David seemed to be saying that he could not meaningfully engage his future without also engaging his past.

“I’m not sure if you told me that.”

“Well, I’m going to kill myself—or I wake up in the morning and I say, ‘Oh I wish I was dead.’ And I say ‘I’m gonna kill myself.’ But I ain’t gonna do it. I have to say what I am going to do, but I don’t do it. It’s negative. That’s part of me that I do. That’s all I ever do…I want to drink, but I know the consequences.”
I remembered David had mentioned that he had these recurring thoughts that bothered him (e.g., going to hell, striking others). I said, “Oh, like the last time you said you had these thought that you wanted to do something.” David loudly interrupted, “Stop!”

“Just stop doing this,” I said.

“Yeah, like I just wanna knock the shit outta someone while I’m standing right by them, just to see what happens.” David laughed and continued, “Yeah, that’s what I’m thinking in my mind, ‘Oh God, no don’t do that.’ Or, you know, fight and get the shit knocked out of me. Or, I’ll get stuck in this hospital, or go to jail, you know, weird thoughts.”

I asked him how the diagnosis affected how he saw himself in the future. David explained, “It helps me. It’s helps me change...It makes me think, ‘Don’t think about negative thoughts.’ No, I mean they happen to you, yes, and it could happen to anyone. And, you, you’re not the only one. I mean it’s not about just me me me me me, there’s other people that have been in my situation and there’s people that have been in the exact same situation probably, there has to have been, I’m not the only one in this world. I gotta let it go, yes, like Will said, but I need to express it before I let it go. Do something to let it go and just forget about it and go on with my life. Make up with these people. Don’t tell them some of this stuff, but make amends with them. And just carry on, and if they hurt me, so what? I mean, if they don’t apologize or if I never tell them that ‘Oh, you hurt me.’ Tell them in a nice way, depending on the situation, and love them and care for them. Just tell them how I feel. Don’t abuse people or if you feel aggressive, walk away, count to ten, do something like coping skills, things like that. Go for your dreams and don’t let anyone hold you down. That’s what that’s what I feel from that.” I was surprised that David expressed himself in such a solid manner. Not only does he describe how he feels but he is aware of the complexities of engaging others (e.g., “carrying on” even if they do not apologize). Furthermore, it appeared that the diagnosis inspired hope in that he saw himself as being able to change behaviors that bothered him. It seemed that because the diagnosis provided an understanding of thoughts and behaviors that were troubling to him, David saw himself as having the strength to put his plans into action.

“Getting all that past stuff out there, figuring it out would allow you to move forward.”

“Yeah, I got a success story in my head, and I know personality disorders, which I heard that people are disea-, are mental illnesses, it says that people think about it, talk about it, but don’t do it. You know, but not me, ‘cause I know. I talk about it, but I’m also gonna show
people. If I can get out of here and go to school, did I tell you that?” I nodded and he continued, “If I get there, I will do it. It’s gonna take time, but I will. I’m not gonna let no one get in the fuck of my way, sorry. Get the fuckin’ hell out of my way. I’m gonna do it, no matter what it takes, and I don’t care if it takes until I turn 50, I’m gonna get it done. And I will do it.”

“Sounds like you have a plan.”

David continued, “If my mom dies before I do it, at least I know I did it. I am doing it for me, not for her. Not for you, ‘cause you made me see the other side. I am doing it because I want to prove to myself and to my higher power that I am someone, that he made me be someone. I am someone deep inside…Still [subject of sentence undecipherable from tape] sees me as a negative person, probably around women. I don’t know if I should be having relationships with them because my, you know, my behavior.” The rest of his statement was unclear from the tape, but he discussed needing to be in therapy, for the “rest of his life” or, at least a “long time.” There was exuberance in David’s voice regarding his plans even if he had to be in therapy for the rest of his life.

I pointed to the experiential constructivist diagnosis and asked, “Does that help you figure out your anger and your aggression?” David glanced in the direction of the diagnosis, paused briefly and answered, “Yes, where my points are: women, about people caring, people ignoring me, looking for attention and they don’t give it to me. Things like that. Yes it did.”

I asked my next question: “How would hearing this at the beginning of therapy affect your therapy?”

“You mean how would it affect my therapy?” David asked.

“If a therapist came in and said, ‘This is how I understand what’s going on with you.’”

“I would say, you know, give me more in depth of what you think. I wouldn’t be doubting them. I would just want to understand what they mean more, because I’d want to cope with them more in my mind, and see what you’re trying to say. I can’t be like them, be a doctor, but I would say, yes, I agree with it. I would want to know more what they mean by some of these thoughts. I mean some of these thoughts are very, very easy to get, but some are more complicated.”

“So, hearing this at the beginning of therapy, you would want to know more about what they think about,” I reflected, hoping that David would elaborate his thought a bit more.
“Yeah, yeah. I don’t want to be doing their job. I just want to know more about me. I just want to see how they came to that, ‘cause I sure as hell couldn’t come up with that.”

David’s desire to understand his therapist more upon hearing the diagnosis may be due partly to the confusion he feels concerning his constructions of the world.

“Oh, so you’d want to know what they were thinking about to come to that?” I asked.

“Yeah, ‘cause I couldn’t write that about me. I couldn’t! It’s very good. I mean it’s awesome. How you do that? Very good. I mean you did a good job…you got it down,” he said, punctuating his statement with laughter. It was difficult for me to understand his praise, as it felt effusive.

I asked him if he would be comfortable with others hearing this diagnosis. He said he would but did not elaborate. I moved to my next set of questions. I asked David to imagine a hypothetical therapist that he knew nothing about other than she or he was using the experiential constructivist diagnosis to understand him. “What would you think about this therapist?” I asked.

“I’d say, ‘I don’t want to talk to you again no more.’” His response took me by surprise, as he had positive things to say regarding the diagnosis.

“You don’t want to talk to them.” I said.

“I’d say, ‘Why do you feel that way? I mean, what made you come up with those thoughts?’ I’d say, ‘I agree with you on some of ‘em, but I want to see why you wrote these things. Tell me why? Tell me why? I don’t understand.’ I’d be saying that a lot. ‘I mean, I don’t understand why you’re saying that? Where you’re getting that from?’”

“So, does some of it not fit?” I asked, as it seemed as though we were miscommunicating or I had misheard him.

“It does fit! I can’t cope with, I can’t, I can’t focus—not focus—I can’t comprehend. I’m trying to comprehend, but it does. I do understand it, and I can’t comprehend at the same time.”

I tried to reflect this back to David and said, “You understand the words” before he interrupted me.

“I do understand it, but what I mean by comprehending is like the in-depth ones. The ones I asked you questions on. I couldn’t comprehend that.” David communicated that he would
be petrified about what the therapist might know about him, if he or she could give him such a description of his struggles.

“The questions that I had?” I asked still a bit confused. At this point, I thought David might be threatened by the diagnosis, as it afforded him the opportunity to think about his life in new and different ways.

“No, the one’s I asked you questions on. I didn’t know what you were trying to say until you told me. That’s what I meant,” David explained. While he seemed to be saying that parts of it needed my clarification, I could not reconcile his need for clarification his first reaction to my question regarding this imaginary therapist. David continued, “I did comprehend it. Yes. I had a bad childhood and I felt neglected. And, I use people to get back what I wanted: money, sex, being in sexual relationships just for sex, using my parents for money. I understood all of it.”

“But there was part of it that,” I began, but David interrupted to explain. “Like those three questions I think I asked you,” he said. I asked, “So, after answering those questions, where you able to comprehend it?” David said, “Yes. I understand it more.”

I wanted to know more about what David thought and said, “You’d want to keep knowing more from this therapist.”

“Yes. ‘Cause it would be a good therapist,” David explained. At this point, David’s strong reaction to the imaginary therapist question seemed to mean that the therapist would be a “good” therapist, but also threatening as the therapist could understand him in ways that David could not articulate himself.

“Can you say more about what you would think about this person?”

“Sometimes, yes, sometimes no. It would depend on the session we had. But, I wouldn’t give up, I would have to keep going.”

“How about just based on this what would you think?” I asked pointing to the diagnosis.

“Yes, I would like them,” David said. “Why would you like him or her?” I asked hoping for an elaboration. “Cause they’ve gotten that far to know me, and I would want to keep going with them,” David said. I understood his statement as a communication of trust in the therapist. Because the therapist took the time to understand him, he would want to continue working with this person.

“Would you say that you would be starting to trust him or her?”
“Yes, I would start to trust them,” David answered but did not elaborate further. I moved to my next question. “Do you think this therapist trusts your experience of your struggles?” David looked at me as though he did not understand me. “Let me put it differently,” I paused to think for a moment and asked, “Would this therapist believe you?”

“I pray to God they would. That’s all I can say. I’d like to have a lie detector test every session that would [makes buzzing sound] every time I lied. I would not lie,” David said. By asking this question, I hoped to gain a sense of how clients would construe their therapist. While I intended the question to understand how participants would construe their therapist, David responded as if he believed his therapist would be suspicious of the veracity of his words.

“Because you don’t want to be seen as,” I began. I was going to say “a liar or a manipulator” before David interrupted me. David continued, “I don’t want that shit no more. That shit’s gotta go. It has to go. If I lie to you, how can I trust myself?”

“Exactly,” I replied.

David continued, “I don’t know what came up with that thought, but I think it is a psychological thought. If I lie to you, how can I trust myself? If I lie to you, how can I trust myself and God? I mean, which I am tryin’ to believe more into Him than then you, you know what I’m trying to say? Like, if I lie to Him and I’d be lying to you, then I couldn’t trust myself. That would hurt me more. It would get nowhere.”

“So, if you’re lying, it means you’re lying to yourself, you’re lying to the person that is in front of you, and you’re lying to God.”

“Yes, all at the same time,” David said, seemingly resonating with my statement.

“All at the same time.”

“All three of us are being lied to. So, it’s not helping one per—it’s not helping me and it’s hurting Him, too. And, it’s hurting you, ‘cause I’m wasting your time.”

“How does it hurt me?” I asked.

“It would make me believe something that I am that I ain’t. Make me believe that I’m someone that I’m not really not supposed to be or that I think I am but—can you help me out with that?”

“You’d make me believe in. I think what you are saying is that you would make me believe in lies,” I offered.
“Yeah. And it’s true, but they’re not, yes. I say, I’m a rock star—I’m going to be a rock star—I’m a rock star, man. No, I’m not. I’m just a guy who likes music and tries to make music, but I know I can’t. I love to say I play the drums, but I can’t play the drums. I tried to learn, but I couldn’t do it. I tried. Sorry to say, I lied to people here…and I made myself believe it, and I told people that,” David explained. I wanted to know more about how lying to others was linked with lying or deceiving himself. Because of David’s struggles with self-other permanence, it seemed that “lying” to himself may not have been completely accurate. *It may have been more accurate to say that parts of David may have believed that he was a drummer or that the more he told lies to others, the more he could not differentiate between was true and false about his own life.*

“Part of you believed that you were a drummer.”

“Yeah, now I’ve found out that I can’t tell these—do this shit no more. This shit’s gotta stop,” David responded. *It appeared he validated my hypothesis. The deceit he describes seems to be more than lying. David stopped and corrected himself. It is not that he cannot tell these lies anymore, he cannot “do this shit no more.” It seemed as though David realized he could not contort self and other in ways that made the world more confusing for him.*

He went on to apologize for cursing so much. After I assured him that I was not offended, I asked my next question: “How do you think your pretend therapist sees your ability to change?”

“I’d have potential. I got what it takes. I know I got struggles, and I got, probably got problems to deal with and I need to learn how to use coping skills. I gotta take time to talk with him, be seen at least once a week or once whatever he wants. And, read books. Do some things he suggests and use the tools, and make my own tools, too…I can’t rely on him for life but you got you got to be—I know I got what it takes to do it. I think of it as a confession session. What’s really making me struggle in life and the negative thoughts are in life and things like that. It would help me, that’s what I would think you would do.” While much of David’s words were the rhetoric of the hospital (e.g., learn and using coping skills, a bootstrap mentality), the diagnosis appeared to give him a sense of confidence or strength. *Furthermore, David has some awareness that he cannot solely “rely” on his therapist but he would need to be open to this therapist.*

“So, this person using this understanding would trust you, have confidence for you.”
“Yes. Hope,” David responded.
“What makes you say that?”
“Mm, hope?”
“Yeah, why is,” was all I could say before David said, “Because I know it is the truth.”
David seemed to think that this therapist would believe that he would be able to move beyond his present struggles.

“Why do you think that about this therapist? Using this understanding.”
“I confided in him and I told him the truth, and nothing was a lie. I told him the truth, if Medicaid or Medicare read this, I don’t care ‘cause at least I’m telling the truth. I think there’s people out there fucking using them like goats and milking them like cows, man. I mean I’m sorry! I’m tru—yes, I am. ‘Cause, I don’t know if I need social security or whatever, I can’t work right now, but, I mean, that’s beside the point, we can go on.” For David, telling the truth was connected to not “using” the system.

Unfortunately, we did not explore this response further, as I asked my next question.

“Ok. So, a therapist using this understanding would be effective for you?”

“Yeah, I think he would be able to. I believe he would have confidence in me rather than just mis-, mis-, what’s the word I’m looking for—deceive him. I know I’ve deceived Will occa—I know I deceived him. I wanted to deal with my past, but he didn’t let me, so I did didn’t deal with it, so I that’s all I could say. But he helped me learn about the future, tell me more about how to achieve my goals, which I want to deep down don’t wanna do it, but gotta go on and cope with it. That’s what he taught me.” As David mentioned previously, there was little difference between deceiving himself and deceiving others. David believed that he was deceiving himself and others when he did not discuss his past. Furthermore, his past would need to be acknowledged and honored in order to have a meaningful sense of hope for the future.

“So, it sounds like trust for you is like—”

“I have to trust him. He went to school to figure out how to help. And, if someone is out to help me, I’ll take it. But not use ‘em. Don’t use ‘em. Use them for your help not for your advantage. What I mean by advantage is like, I say, ‘I gotta problem that I want you to solve for me.’ I want to tell him my thoughts on the problem, what I think is right, how I truly feel about it. That’s what I mean have a problem a problem which you solve for me, and I want to tell him
my thoughts on the problem, what I think is right, how I truly feel about it. That’s what I mean.”

David seemed to believe that asking for advice was akin to using his therapist.

“So, you don’t want to get advice from them, you want to be able to tell them what you are thinking about?” I asked.

“And, the situation and how I am going to handle it, you know?”

“So in asking for advice, you would be using them?” I asked.

“Yes, it’s like me coming here and telling you what my thoughts are. My thoughts are like the goals I told you before. I told you what my thoughts were. I didn’t ask you, ‘Oh, what should I do when I get out of here?’ Is that the correct thing for it?”

“If you were asking for advice, it seems that it would feel like you were abusing them, but it seems like you were talking about how you felt about it.”

“My thoughts, my thoughts,” David said.

“Which weren’t a lie,” I said.

“Yes, that’s right, that’s right,” David said enthusiastically.

I moved to my next question. “Do you think this therapist whose using this diagnosis would be limited in her or his understanding of you? Would he be missing something?”

“Not that I know of, no. No, they wouldn’t.”

“So it feels as though they would be able to understand you,” I said, trying to understand David better.

“Yes,” David replied but did not elaborate any further.

Presentation of DSM Diagnosis. After making sure we had enough time to begin the second diagnosis, I invited David to read the DSM diagnosis. We decided that reading the diagnosis aloud would be beneficial. Other than agreeing that he felt depressed, David made no comments about the diagnosis. He asked a few clarifying questions. Realizing that David may have trouble comprehending some of the terminology of the DSM diagnosis, I played an active role in assisting him.

“Any question about this one?” I asked, wanting to be sure that he understood the diagnosis.

“Every time I did have one, I stopped and asked you,” David replied.

“So does that make sense as a whole?” I asked. David hesitated, and I asked if he would like me to summarize it.
“Yeah please. That one was very hard. I tried my best. It boggled my mind…That one I give a B+ ‘cause you boggled my mind!” David exclaimed. I asked him for the diagnosis and, as I read through it, I explained the concepts to David so he could understand them. David asked questions and offered examples based on people he knew at the hospital. After David felt he understood the diagnosis, I asked him my first question.

“How do you think this describes your strengths and weaknesses?

“Some of these things—like the—I don’t—they’re not really—not as—has nothing to do with me, but I think they do, but then it doesn’t and that over time I’m—” David said before trailing off. I had trouble understanding what David meant and assumed he had trouble with this question.

“Say that again. I’m not sure I understood.”

David tried again and said, “At first I may have said, ‘Oh, that’s me! That’s me!’ But, I’m not really that. I say it’s me, but it’s not me, and I know it’s not me. That’s my strength.” I thought this statement reflected his struggles with self-other permanence, as he could not experience changes in himself in a cohesive manner.

“Are you saying there’s things in here that aren’t true?” I asked.

“They are true! But, I can tell myself they’re not. That’s my strength. I can try to fool myself, not fool myself, but think myself believe they’re not but I know they’re true.

“Mm,” I paused, not fully understanding what he meant at the time.

“It’s hard to understand, I know,” David, seeing my confusion, replied.

“Why don’t you give me an example?”

“Well, like hallucinations, my strength is I can let ‘em go and just ignore ‘em. Ignore them, that’s what my strength is.” It appeared that David validated the diagnosis, in that he experiences hallucinations, but felt his ability to ignore and control his hallucinations was a strength.

“Ahh, ok.”

“My weaknesses would be—well, about everything in there, my point of view would be.”

“It gets more at your weaknesses?” I asked.

“Yes, the first one [EPCP diagnosis] is more my strengths and this [DSM diagnosis] is more my weaknesses.”

“How does this help you see yourself in the future?”
“Stuck in a state hospital probably—for the rest of my life,” David replied.

I attempted to reflect his sentiment that it made him feel as though he needed to be in a state hospital but David interrupted me and said, “A group home… or nursing home, that’s what it seems. Of death.”

“Death. How so?”

“I’d think there’s no hope for me, especially after those last few lines. I’d think, ‘Oh, I’ll go kill myself and all.’ It’s a lot to take,” David answered.

“So, that’s what this one makes you feel?” I asked.

“Yes.”

“So, it seems like it would be hard to figure out how to change using this understanding?”

David replied positively but did not elaborate. I asked my next question, “How would hearing this at the beginning of therapy, affect your therapy?”

“I think the therapist would say, ‘Well this guy feels like he’s hopeless, but he could probably change. You know, I just said no today, I can’t change, but I would hope that the therapist wouldn’t give up on me. I don’t want to be crying on to him about—I would come to him for help, I would ask him for advice, how to carry on, what should I do? What should I do? Not needing love and nurture, but he could give me guidance.’

“Before you said you didn’t want to ask advice from therapists ‘cause then you felt like you were using them.”

“This one would be different, I think,” David replied.

“This one would be different. You would want to ask him for advice. Would you feel like you were using him?”

“No. I think it would be constructive. It would be like me saying, ‘Well, I feel like I should do this.’ And, he would say, ‘You should feel like this and during those situations you should do this.’ Something like that.”

“So, it almost sounds like, in this one, it would almost—it feels like it’s harder for you to change and you would need to ask more advice and more guidance than you would with the other one.”

“Yes.”

“Would you feel comfortable with this one being given to other people like case workers or even insurance companies.”
“M-hm.”

“So, let’s do this like imaginary exercise, you know, with this pretend therapist. So, you never met this therapist face to face and the only thing you knew about them was that they used this understanding of you.”

“Ok.”

“What would you think of them?”

“I think, hopefully, they would be able to save me, I mean not save, but like get me out of this rut and reverse my thoughts and my point of view. You know, perspective, my point of view, how I perceive myself and how they see me.” David seemed to say that the therapist would need to save, or focus on changing how he saw himself. In contrast to the experiential constructivist diagnosis, David placed much of the responsibility for change onto the therapist.

“How well would this therapist understand you?” I asked.

“How would he? By reading that over and over hopefully,” David replied seemingly misunderstanding my question, although the impersonal nature of his response may be telling.

“You think he or she understands you well, or not so well?” I asked.

“He understands pretty good. He perhaps understands what I felt,” David replied, but did not elaborate further. I wondered about the qualifiers in his statement and replied, “So, he would understand you?” stressing the question mark.

“M-him.”

David did not seem to have too much to say regarding the hypothetical therapist, possibly signifying that it was difficult for him to come up with an image of this therapist. I moved to my next question: “Would you feel victimized at all?” David did not seem to understand what I meant, not surprising as the prior two participants did not seem to understand my question either. I defined victimized in terms of the victim of a crime and, taking my explanation literally, he said he would not feel hurt by the therapist. I rephrased my question and said, “Not that the therapist did wrong to you but that something happened to you that is outside of your control,” which was closer to my intention with this question.

“Yes, I feel that...that is another question. Yes, I’d feel I’d be the victim,” David answered.

“Do you think this therapist trusts your experience of what you are saying? Would they trust you?”
“I hope so, ’cause I deep down gave them something I never told anyone before,” David replied. Like the other participants, David had to hope, or use some internal understanding to believe the therapist would trust him.

“So, does most of what this describes fit for you?”

“Fit for me?”

“Yeah, does it make sense? Do you have the experiences this describes?”

“This the not—the hallucinations—”

“Not the hallucinations?” I asked.

“No.”

“How about the other things, like delusions?”

“Um, I feel someone who I am and then not.”

“How do you mean?” I asked, needing more information to understand.

“Um, I may be mentally ill or not—I do not know. That’s what I need to know,” David said. There was a heaviness to his words. Personally, I felt pained when clients asked themselves if the term mentally ill was appropriate for them in the context of delusions. I often heard mental health professionals refer to persons as delusional if they did not buy into the notion that they were mentally diseased. Not only was this a way of indoctrinating them into the mental health system, it hindered any questioning of the self: Who am I? Why am I in pain?

“I’m not sure if that is a delusion—it seems like a legitimate question to me.”

“I don’t know. I mean that’s what I need to know…if I am, I would like to know what it is. I wouldn’t go around saying, “Anthony told me this and that!” I would keep it to myself and, not tell my doctor. Whatever you tell me it’s gonna be true, it means a lot. People on the tape won’t know what I look like. There are tons of David Tompkins out there. One time, I looked up my dad’s name on the computer. You know how many damn pages they gave me. Four pages!!” David seemed to understand my hesitancy to answer his question as some worry that he would use what I said to argue with his doctors. As I complicated the idea of diagnoses with my project (e.g., giving out two different diagnoses), I assumed David knew I would not say he was mentally ill.

I told him we should wait a few moments to get into the question of being mentally ill, and I asked my next question.

“Ok. How do you think this therapist sees your ability to change?”
“It’s gonna take time. Time heals all wounds,” David replied, again placing the responsibility for change outside of both him and his therapist. **Like an illness, his struggles would appear and then with time (and some medical intervention) would go into remission.**

“Would this therapist be effective for you?”

“You mean help me?”

“Yeah.”

“Oh, I hope so. I mean I would give him all credit, and I’ll give him hope and I’d give him all my trust in him. I would trust him. I would be confident, he would help me, yes.”

“So this understanding would be helpful for you?”

“Yes.”

“Would you trust the therapist using this? Would you trust the therapist using this understanding of you?”

“In the second session, yes,” David replied.

“In the second session you would trust him.”

“Yes.”

“Can you say more?”

“Because that would be the problems that are in my past—that I can’t let go of. I’m trying to deal with them but it’s holding me back I think. It’s holding me back.”

“Can you say more about feeling like you are held back?”

I want to believe—that’s the truth, but part of me wants to believe that none of it’s the truth. So, much is holding me back. I just want to learn how to forget about it, and I can’t.”

David believed that he could trust the therapist in the second session. **However, he also felt that the first session would be similar to our first meeting: the therapist would construct an understanding of him by getting to know about him. Once the conversation was over, David could hopefully “leave it behind.”**

“Would this therapist be missing something?”

“Honestly…maybe a couple things. I can’t think of any right now that come to mind. I guess that he’d be missing about some things, yes he would.”

“Like what?”

“Like there will be symptoms that I remember later and the next time I would tell him, ‘Oh, I forgot to tell you this.’ I wouldn’t do it on purpose—just ‘cause I move around and talk a
million miles an hour, I miss stuff. I want to get it all out and I don’t know how to talk slowly, like I am now, remember? I move around and I talk like this, and like that, over and over. I’m not using it as a coping mechanism. I’m using it as a crutch sometimes. That’s why I would say, yes, he’s missing things…I don’t know what, but he is,” David responded. *He seemed to say that, due to the way he spoke and presented information, the therapist would not know things about him, but he did not speak to the ways the diagnosis captured, or did not capture, parts of him.*

“Oh. Now, let’s take these two and compare them a bit.”

“Um, I’m not too sure what to say, ‘cause I don’t understand how to do that.”

“That’s alright. I can ask you some questions and we can go through it together.”

“Alright.”

“Well, why don’t we start with which one you prefer?”

David tapped on the DSM diagnosis and said, “This one.”

“Why’s that?”

“Because I wanna know what that means. About what it means to, learn more of what they describe.”

“I’m not really sure I understand,” I replied. In addition to being confused by his words, I also expected David to prefer the experiential constructivist diagnosis from our conversation.

“Well, I’m basically asking what do you think I am, what’s the deal?” David replied. I wondered if this referred to his question regarding mental illness.

“Well, I guess I’m asking which… which one of these do you like better?” I asked, as it seemed David was more concerned about how others diagnosed or saw him.

“The second one we did,” David answered again.

“Can you say a bit about why?”

“Made me realize—it opened my eyes more,” David explained. I began to reflect David’s response, but he began, “Even though it was negative, I want to be able to change and trust in someone and get help, see what’s wrong with me. So, I like that one.” The DSM diagnosis made David realize more about himself even if he was cast in a negative light. I was still a bit confused, mostly because his response did not seem congruent with his responses regarding the diagnosis. I also would note my obvious bias in which one I wanted participants to prefer. *While discussing each diagnosis was relatively easy, I believe I had more difficulty with*
the conversation regarding preference and left it for the end of the interview. While I initially had not planned on asking for a preference, the first participants inevitably stated which one they preferred. Therefore, I decided to ask about preference more directly.

“The first one, you feel doesn’t do that.”

“Yeah, it gave me hope. But, I wanna know deep down inside what’s wrong. I know I got hope, and I can get it—deep down inside I wanna know what’s wrong before I get hope,” David responded. His response indicated that giving someone hope prematurely could be dangerous. While I did not think the experiential constructivist diagnosis did not offer hope prematurely, it certainly is built into the theory and would then come across in the diagnosis.

I paused and reflected on David’s response and he said, “I just want to know, that way I can forget about it…Just try to put it back in the back of my head and not look back at it. You know what I mean by that?”

“Say that again,” I said, with a confused but interested look upon my face.

David tried again and said, “I know that’s there and put it in back of my head and do what I got—put it in back of my head and not look back at it again. Just go on. And hope. In order to put it back in the back.”

“Now I’m a little confused because before you said you would like to talk about your past.”

“Yeah, yes, and what I meant by talk about my past is just tell them my confession. Why did this happen to me? What did I do for this to take place? What did I do wrong? I mean, why would I even think about doing that? I would ask you…and you’d say, ‘Well, why did you do it?’ like your parents when they’d say ‘Why did you it?’ and I’d say ‘I don’t know.’ Things like that. You understand now?” It is important to note that when David asked the “why did you do it?” his voice raised and became very stern. When he responded to these questions, there was a sheepish, almost cowering, quality to his voice. At the time, I did not fully realize what David meant. It appeared, however, that David did not want to explore why he had behaved in certain ways for fear of punishment.

“You wouldn’t have wanted to talk about those things.”

“No, I wouldn’t want to.”

“You would just want to tell someone about your past, put it all out on the table.”

“And then just forget about it,” David said.
“And just forget about it. So, are you saying the first one focuses a little too much on your past?

“Yes.”

“And, you want to focus more on getting how to forget your past.”

“Yes… I just want to, you know, cope with it… and that’s why I told you about the things I did the first time we met. So, I didn’t do it with Will ‘cause I didn’t feel comfortable with him. Felt comfortable in other ways, talking about the future, but, with you, in a different way. If I had to choose, I would choose to get through to you,” David explained. David and I seemed to have different understandings of his past. While I referred to his childhood experiences or the things done to him, David seemed to be focused on the things he did to others. At the time, I did not realize this distinction, which would have been useful.

“It sounds like it’s important to understand all those things that happened to you in the past, you just want to talk about them, get them out in the open.”

“Yes.”

“Understanding how they affect your life now is not really as important for you,” I inferred.

“No. I know this happened and that everything happens for a reason. That’s what happens. Everything happens for a reason. It’s all planned out by Him.”

“So, is it important to figure out why, rather, figure out how—” I began but David interrupted me. I intended to ask if it was important to figure out how these things affected his life presently.

“That boggles my mind, that’s what I think. For other people it’d be different, for me it would confuse my mind…I would just sit there and ponder on it. And the doctors had to do that. Some of them—I don’t know what they to do—I would just sit there forever.”

I tried to reflect this back to David: “So the first one would make you dwell too much on the stuff that happened in the past.”

“Yes, dwell on it and sit there and go, ‘Oh God, man, I think—’” David trailed off but seemed to say that he would be mired in his past.

I asked my next question: “Which one do you feel is more accurate?” David did not seem to understand and I asked, “Which one describes you better?”

“The first one describes me better, it talks about how I use this system.”
“So, the first one describes you better [David: Yes], but you prefer the second one.”
“Yes, I would prefer the second one.”
“Because that would go into all that stuff,” I said as I pointed to the experiential constructivist diagnosis.
“Yeah.”
“So, the first one in some ways is more accurate, but you don’t want to—”
“I don’t want to admit to it.”
“You don’t want to admit to it. The second [DSM] one doesn’t touch that stuff.”
“No.”
“But it [DSM] does like describe you pretty well, but not as not as accurately as the first one,” I said attempting to summarize his thoughts.
“Not to the point that the first one does. The first one it’s more detailed—more detailed, or more exact than the second one.”
“So, let me summarize what you have said, so I can be sure we are on the same page. The first one [experiential constructivist] feels more accurate, but it stays too much in the past. You would like to talk about it and get it all out, but you don’t want to stay there. And this one [DSM diagnosis] doesn’t go there—maybe not as accurate but it feels better for you to stay here.”
“Yes, it feels better to stay there,” David replied.
“Okay.”
“‘Comfortably Numb,’” David said.
“I’m sorry?”
“‘Comfortably Numb.’ You know that song ‘Comfortably Numb?’ The [Pink] Floyd song.
I paused for a few moments searching my memory for the lyrics of the song and its meaning in the context of our discussion. I was taken aback and all I could say was “That’s interesting. Very interesting.”
“Am I an interesting person?” David excitedly asked.
“I think so,” I said, aware of the criticisms David had received over the course of his life. David then assured me that he was not lying. Even though I conveyed that I believed him, he continued to describe how he had manipulated doctors by making them think he was “sick.”
quickly reiterated that he was not manipulating me. I moved to my next question and asked him if his thoughts regarding the hypothetical therapist would change depending on the diagnosis they used.

“I would think he came to a good conclusion and thought it out well,” David responded. I did not understand which diagnosis he was referencing and asked, “Which one?” “Either one… I’d ask what he picked and what he came up with, and that’s all! It’d be like that!” David said snapping his fingers, indicating to me that it did not matter as long as he or she took care in constructing the diagnosis.

“What would you think would be more effective or helpful for you?” I asked. “Mmm,” David paused for a few moments, “I would want to change so it’s number one [EPCP diagnosis].” “You’d want to change, so number one would be more effective,” I said wanting to be sure I understood. “Yeah.” “So, like you said before, it’d be hard to do therapy with the first one.” “Yeah.” “It would be easier to stay comfortably numb.” “It confuses me to go back and forth… I want to change ‘cause I don’t want to be using the system and stuff, I don’t want to do that stuff, and I don’t want to be a liar, I mean I just want to change,” David said almost remorsefully. “Which therapist would you be able to share more personal information with?” I asked. “It wouldn’t matter.” “Would you trust one therapist more than the other?” “Yes.” “Which one would you trust more?” I asked. “The second one,” David responded. “The second one. Can you say why?” “Oh! Sorry. I mean I would trust the first one ‘cause I told them the truth about me. The reason why is I would want to see what is going on with me. I would trust them more for some reason—it’s just a feeling I have inside… you know, I’m gonna change and I’m willing to do it. I’m sick and tired of being sick and tired… It’s gotta change.”
Alan

Alan was a 30-year-old, Korean and Caucasian man who had spent the last year in the hospital’s substance abuse unit. Alan had finished the hospital’s program and was scheduled to be discharged in about three weeks. Upon discharge, he was planning on moving across the country to live with his mother. Alan’s parents had divorced when he was six or seven years old and his mother had moved across the country to live with her family. While in the armed services, his father met his mother in Korea and she moved to the United States to marry him. Reconnecting with his mother was important for Alan, as he wanted to learn more about himself through his mother. He knew little about his mother’s perspective on his childhood. He was also unaware of his Korean cultural history. While Alan appeared depressed much of the time, I had the sense that, for the first time, Alan had some sense of hopefulness concerning his life.

Alan had been hospitalized three times, each for suicide attempts and had received numerous combinations of drugs and a wide variety of DSM diagnoses, including Major Depressive Disorder, Bipolar Disorder, Borderline Personality Disorder and Avoidant Personality Disorder. Alan had a long history of violence towards himself, beginning with a suicide attempt at the age of eight. Alan began to drink heavily in college and continued until his mid to late twenties. While drinking heavily he lost his driver’s license and his suicide attempts usually involved the use of large amounts of alcohol.

Alan and I met twice during the course of a week. Our first meeting lasted for roughly two hours. While the diagnosis group did not use the last quarter of the interview for diagnostic purposes, I will describe it briefly. It affected the way we wrote the EPCP diagnosis as well as they way I interacted with Alan in later interviews. I will describe the two-hour research interview in detail. The audiotapes from this interview were difficult to understand and parts of the transcripts are my approximations of our words.

Diagnostic Interview. Because Alan’s unit was in a different building than mine, I had Alan’s therapist introduce me to him. Upon meeting Alan, I was immediately struck by his sad expression. When I first introduced myself, Alan met my gaze only momentarily and immediately cast his eyes back to his shoes. My first observation of Alan foreshadowed a tension I experienced when speaking with him. On the one hand, Alan would relate intimate and painful memories, but did so in a way that it made it hard to connect with his experiences. For instance, Alan would not engage in much exploration of his experience or even look at me to see
my reaction to his stories. I thought Alan did not want to explore his experiences in depth, as his constructions could easily topple with the slightest budge.

Alan and I met in the late afternoon, when the classes, groups and structured activities were finished for the day. I described the purpose of this interview and asked Alan to tell me about himself. Alan responded, “The first time I ever like went into the hospital for anything I was eight years old. My parents had been divorced for a year probably and I tried to hang myself. I didn’t really know what I was doing—it didn’t even come close to working, but my sister was right there. So, she saw it, she was only six or seven, and she somehow knew what to do. She called my dad’s office and he came down and I spent a couple of weeks in a hospital in Louisiana for that.” Alan spoke with a regretful tone about the suicide attempt and he seemed to feel like a terrible person because he tried to hang himself in front of his sister. While each of the previous participants began their interview with a similarly disturbing story, I was taken aback by his tone and asked a much safer question.

“Is that where you grew up?”

“No, my Dad was in the Army so we moved around a lot,” Alan answered before continuing his story. “I’m not sure what happened the next few years. I guess I don’t really recall having any kind of problems. When I was ten, my step mom came into the picture. It was kinda out of nowhere. My dad just told us we were meeting a lady at a campground and I never met this lady before. We were living in Arkansas at the time and she was still living in Louisiana. And, my dad was a recruiter and he recruited her. I don’t know if there was anything going on before that or not. It was really kind of awkward and she had a son. By the end of that weekend, on the way back to the house, my dad was talking about calling her ‘Mom’—I had never even met this woman—I didn’t know what was going on. I feel like I blame her for a lot of things, but I think that she is a very hot-tempered lady, and, at the same time, she can be very caring but the temper got a hold of her a lot. I mean we didn’t get physically abused or anything like that but she would yell a lot and we got emotionally abused,” Alan explained. By juxtaposing these two stories, Alan implied that the divorce and his suicide attempt were related, but did not do so verbally.

“What sorts of things would she say?” I asked.

“Well, she wouldn’t call us anything. She just—well, maybe not emotional abuse—she would just yell at the top of her lungs and you’d know that she was upset and stuff like that. I
guess she never came out with really direct—she wouldn’t call us anything. I’m not sure how to describe it to you. She just made a lot of noise and it wasn’t a very good environment to grow up.”

“It sounds frightening,” I offered.

“Yeah, so, I was ten and they got together and I started noticing that I started having thoughts again about suicide and I wasn’t really sure why. I’m not sure if it was her being in the picture. I didn’t really act on them for a long time and the only way I saw it happening was with a firearm of some sort and I never had access to any of that. So, I did pretty good not trying anything until I got to college.”

“Before you go there, can you tell me a little bit more about when you were eight?”

“My parents divorced and I don’t really know if I took it all on myself ‘cause my dad told me and my sister, ‘Don’t blame yourself,’ and she just basically left. I don’t know anything about the divorce. I don’t now how they worked it out I just remember she wasn’t around. And, um, I tried to take a couple of bungee cords and I hooked them around the doorknob and over the door. Then, I stood on a chair and tried to loop around it. I was only eight and I didn’t know what I was doing. It pretty much just fell apart as I, you know, jumped off the chair. And, my sister was right there. I don’t think there was any other circumstances that went in to that. I mean now I have tried it a few more times and, when I look back, I get the feeling that the records show that maybe I was just trying to get attention. I don’t think I was trying to do that but I don't know.” Alan’s uncertainty around any experiential connection between his parent’s divorce and his suicide attempt may be further evidence of the disconnection between Alan’s inner and outer life.

“Were you upset by your parent’s divorce?”

“I mean I was dealing with my parent’s divorce and it was big deal not knowing whether I was going with my mom or my dad. It just happened, I didn’t even see it coming,” Alan explained.

“Wow. Did it seem to you their relationship was alright before that?” I asked, as I was unsure if Alan did not realize the turmoil in his parent’s divorce or if it was too difficult to keep these painful memories in conscious awareness.

“Um, yeah. Kind of okay. I mean they had some arguments and stuff. I’ve come to find out here recently, which bothers me a lot, that my dad may have been kind of physically abusive
towards her—not like really bad—I know any abuse is bad, but, you know, and that kind of bothered me a lot,” Alan said. Perhaps he did struggle to keep these painful experiences of his past in his awareness.

“And you don’t remember that?”

“I remember them screaming a lot, but I don’t really remember my dad being physical, but—so, personally, I didn’t know who to blame. I was my dad’s son and I was always going to take his corner, but, now, that I know a little more, I feel really bad about what my mom went through and stuff. She was Korean. She only had a fourth grade education in Korea, and she was the oldest, so I guess she had to go out and try to help make money to get food and stuff like that…My dad met her over there and brought her back. She may have just been using him to get over here. I don’t know the whole story,” Alan explained. Alan struggled to understand how his parents took responsibility for the divorce. *Alan received the message from his stepmother that his mother was at fault (see below) for the divorce. He also felt abandoned by her, making it difficult for him to take in this new information regarding his father’s physical abuse of his mother. Furthermore, Alan seemed to understand that trusting his father left him feeling hurt in the past.*

Alan continued, “But, she came here and they had me and my sister. My Dad quit the Army for a while, for about a year or something, and was driving trucks. I guess he was kind of unstable and he went back into the Army and I guess early on they had quite a bit of problems. My mom tells me about having to borrow money from my grandparents on his side of the family. She had to work two jobs just to pay it back and raise my sister and I at the same time. She took on things—I guess she took quite a bit. I never realized how bad it was until just recently.”

“You said your dad was unstable.”

“Well, at that time I guess. Now, he’s fine, but I guess, at that time, he had been in the Army for quite a long time, but he just took off the year, and I don’t know if it was the money or the traveling or whatever, but he went back into the military. I remember bits and pieces of that and of my grandpa being around. But, I really don’t recall my dad and mom interacting and communicating that much. I don’t really have a memory of that at that age. I would usually just hang out with my dad, working on cars and playing basketball and stuff like that.” *Much of Alan’s experience was too painful to construe and made it difficult to remember.*

“Sounds like you took it very hard at eight.”
“Yeah, it was hard because I sided with my Dad and my sister was with my Mom. When she left, I didn’t know what happened. It bothers me that I’m so weak as to resort to that ‘cause I mean other people whose parents divorce take it hard too, but they work through it. But, somehow in me, it kind of went in that direction, it went to an extreme and I don’t know why I did that. I don’t even know how I knew anything about that—that’s what I don’t understand. The earliest memory I can think of any kind of suicide was *Full Metal Jacket*. I think I had seen it around this time, but I think it might have been after I tried it, so I have no idea what I was doing. I don’t even know why I would think of something like that. I’m really hoping when I leave here that I can live with my mom and find out a lot more of what was going on. She’s kind of always been tightlipped about it, but I think she can tell me a little more and I really want to hear more from her side, learn more about my Korean side as well.”

“So, you still had some contact with your mother after she left.”

“Yeah, I remember there was a time when we would meet halfway and she would take us for a weekend. But then she picked up [and left], I think she said she had $200 in her bank account and tried to start over. But, I do remember a period where there was some contact, yeah. Especially before my step-mom came into the picture, but when my stepmother was in the picture with dad, we never heard anything about mom, most of the time my stepmother was saying how bad my mom was and stuff like that. That she’s not doing this and she’s not doing that and she’s worthless and stuff like that.”

“Sounds pretty extreme.”

“And, as I said earlier, I hate to blame my step mom for a lot of things, but I know I did for a long time. When I was younger and my mom left, I felt like she, even though I didn’t do a lot with her, I still felt abandoned. Then, when my step-mom came into the picture, even though I was living with my dad, I felt like she kind of took him away. And, I was abandoned by him, even though I was still living with him. I can only recall just like one or two Hallmark-type moments, bonding moments—one or two and that’s it. I mean I would think I would have had a lot more time with my dad, but she seemed to pull him away from a lot of things. I always felt kind of last in the whole family. When my step-mom came into the picture, she brought a son and I felt like he was kinda—you know I hate the fact that I make justifications—but, I kinda always saw him as being number one. It’s her son and I can understand that cause she is the one who gave birth to him and raised him and everything. Then, my sister was kinda second. I
justified that by saying she’s a woman, she’s growing and they need to bond. Like my sister
needed a woman to learn things about being a woman. But, then I say that also she could be the
hardest on her too, as she was growing. And, I was like last ‘cause I had no connection. I don’t
know. I just felt last and I had a half brother. And, I always felt like I was not even there. I
always felt like I had to prove myself in other ways. I mean I was like working in high school, I
lettered in a couple of sports and made it to the top of my class and all that stuff, and I still felt
like I wasn’t worth anything around them.”

“It sounds really hard to deal with all of those thoughts about yourself.”

“Sometimes I just don’t understand why I think about things like that. I guess that’s just the
way I am. I mean I try to justify it, so it doesn’t make them out to be a bad person. I just feel
like there’s a reason behind that and that it’s at least ok,” Alan explained. Alan was protecting
his image of others to the detriment of himself.

“It sounds like it hurt a lot when you were younger and maybe those reasons help you feel less hurt.”

“Yeah, you could be right…there’s just a lot of fighting and argument things like. It’s really weird that when I was eight and I attempted suicide, it kinda got put up in the closet. No one even thought about it. No one talked about it anymore. And, here I am thinking about it every night, every day—it’s an everyday thought. It was about when I was getting into college again, I started thinking of a different way. ‘Cause I always thought about a gun and I could never find one or get a hold of one, so then I started thinking about pills. I wasn’t on any kind of prescription pills. From when I was eight years old, just like I said, it got put away and no one thought about it. I tried a whole bottle, a hundred capsules, of sleeping pills, just over the counter. I did it with water because I couldn’t get alcohol and I did that one night and that was a really weird experience, too. My whole body felt asleep but my head was still racing. And, another thing I don’t understand is that I was trying to kill myself, but I had to use the restroom, so I actually got up. I don’t know what the deal is with that. I couldn’t even move my legs and my arms were real heavy and I used the wall to get to the restroom. And, then, they basically just wore off. I laid down and I finally got to sleep and when I woke up I was fine, so I’m not even sure that I was trying to kill myself, but I don’t know. So, no one knew about that and I got in college. I got in trouble a couple of times with the alcohol and stuff—I didn’t start drinking until I was in college. The year I turned 21 was my junior year and I was drinking every night. I
didn’t try suicide till later, but I started getting in to a lot of trouble. My first DUI was at 21. I
got another one a couple years after that. I ended up getting three DUIs in 5 years, so I was a
habitual offender. The first DUI, I pretty much almost put the car through a guardrail, and I
almost went through the window. I wish now I had got the stiffer penalty on the first DUI ‘cause
maybe it would have deterred me from doing it again. But, I know I have a problem with
blackouts when I drink heavy. So, I blacked out and woke up in a big drunk tank and I didn’t
have to go to court or anything. I had some community service during the summer that happened
near my hometown. The second DUI was in a rental car, my car was getting fixed, and someone
hit me in the parking lot and I almost hit a cop car on the way home. He pulled me over and I
got a DUI for that. I remember going to court for that, but I still I think I had community service.
It wasn’t really that stiff of a penalty. But, the last one I got in that 5-year period, I was blacked
out again and I hit two or three cars and tried to keep driving into the car and ran them out to the
ditch. This is one of the first times it kinda came out for me because I had been holding this in
every day. I mean, on those bad nights, I stayed up all night crying and drinking. But, that third
DUI—apparently when I was blacked out I was asking the cops to kill me. That’s what I was
asking them and they put it in the police report, so I woke up in a padded cell with like a paper
suit. I couldn’t get out of there until I spoke with the psychiatrist. So, I started talking to the
psychiatrist about a lot of this stuff and it just kinda lifted the world off my shoulders—I mean I
felt relieved.’

“About how you wanted to commit suicide.”

“Yeah, I couldn’t believe how great it felt. I just felt relieved, so it started when I was 8
years old and then I was probably 23-24. So, I was in the hospital for a weekend, I on suicide
watch, and I got out. About a month later, I was going to try to hang myself again. I got it all
ready, tested out a tree and got a rope and, my brother-in-law found it and called 911. I had to go
to another hospital and I stayed there for a couple weeks. And, I got out of there, and I don’t
know, I never really got a whole lot out of it. They were just kind of keeping an eye on me
basically. I mean I saw doctors, psychiatrists, but it was all so fast. I don’t even remember what
was going on. But um, that was in 2003, so I was 25, so again I saw lots of psychiatrists and
therapists for a little while but it got to the point where I was getting—this was the first time I
was on prescription drugs. And, I didn’t feel any better and I couldn’t stand taking them because
I was thinking about why I was taking them—because I was suicidal—so it just kind of put that
thought in my head. And, I continued to have thoughts of suicide in my head. I know this is not a good thing to do, but I just stopped taking them at all.”

“Taking them reminded you that you were suicidal.”

“I just couldn’t take it anymore. I remember that I thought I couldn’t do it, but I actually stopped taking them and actually did okay. I started going to therapy too. And, I thought I could do it, there was no pain, then last year happened and, and, I, um, tried to kill myself again. I didn’t know what to do. I went drinking. I was planning to kill myself that night, and apparently I went to the grocery store and they said they had this on videotape, but I don’t remember. But, they said I was just opening stuff up, eating it and throwing it all over the floor. I didn’t really know what was going on. But, I guess I was trying to leave and the cop asked me to stop and I ran. And, at the same time, I had all that stuff in my pocket. I didn’t even try to hide it. I was arrested and then I spent 3 months in jail. And, I wasn’t going to tell anybody where I was. I told people that the court date I knew I was going to get out on. I told them it was just another court date and not to even worry. But, someone found me and my mom was in town, so they all got together and I got myself back in a hospital.” Alan further illustrates the ways his behavior feels alien to him. There is little agency in the way he describes his experiences. I wondered if these experiences were too painful or humiliating to bring into conscious awareness.

Alan continued, “And I spent a month there, I thought I was doing okay and I thought I was going to take my meds again. Unfortunately, a month and half earlier, I started stockpiling. I hadn’t been taking my Clonapine at that point, and I had all these pills. I had about 160 pills and about 50 Seroquel. All I remember is that I put the dresser catercorner to the door and the wall and I took all that and just laid down. And, I don’t remember anything—but they said—I mean I guess from my—I mean I don’t know how they went through the dresser. And, I guess someone was at the door for me, and my roommate that I was living with backed me into the doorway and you could see blood and it looked like a carpet burn basically. So, he called 911 and the EMTs and my case-manager came in. They told me what I had done, but I didn’t remember anything and then I woke up—I was in and out of consciousness in the emergency room. And, the nurses were there in the emergency room. I was trying to leave and he got really mad, and he threw me up on the medical unit. And, I started hearing voices—I never heard voices before—but I could have sworn my mom, my step-mom and my sister were out in the hallway yelling and arguing. And, I thought it was them. I kept trying to get up. I was pulling
my IV out of me and the nurse said I couldn’t leave. She went out there a couple of times and said there’s nobody out there. But that’s the first time I ever heard voices and I haven’t heard them since. But they kept me in the hospital there for two and a half months—they were just nasty.”

“I’m a bit confused. How did you get out the bedroom?”

“Apparently, something with the dresser, they were assuming that I had drug myself on the floor. You know, I don’t know how I did it. I don’t know if anybody really knows. And, I never heard a nurse say anything about there being blood on the carpet, so I don’t even know how it happened. But, it was nasty, my knee looked like a hamburger, raw. This one wasn’t as bad. I really don’t know.”  

Alan’s description of his suicide attempt is another example of the difficulty he has connecting his experiences. For instance, he described stockpiling pills as if it just happened without any intention to kill himself. Alan also seemed to be very conflicted about killing himself. In each suicide attempt, there appeared to be a part of him that kept him from killing himself.

“So you locked yourself in the bedroom and took the pills without anyone knowing?”

“Yeah, I just quietly just took the pills and the alcohol. I fell on my face and I just lay there. The case manager says I was just kind of pointing at his face. And, he said that I said that I was hearing voices there too, but he thinks that I was hearing the EMT, or the case manager, or someone else in the apartment. He thinks that’s what I was hearing there, but I don’t know about that. I was hearing people I knew when I was in the hospital, but I’d never had any of that before, or since, so—I don’t think I have anything like whatever, you know, the people that hear voices, I don’t think I have anything like that. And, then they decided, they told me that the state hospital could be an option. And, at first, I said ‘No.’ But, then I started thinking about it and I thought maybe there’s something I could learn here. But, I think the gatekeeper didn’t want to because I’m kind of a higher functioning person and maybe they could give the bed to someone with more needs, so I was really going back and forth about coming in here. I said maybe I’m gonna try it and go for it. My mom wasn’t too happy about it. She thought about the restraints and all the things people think about when imagining state hospitals. I got here and my sister came pretty early after I was here. She reassured my mom about this and told her it’s not like that. It’s people trying to learn and other things like that, so she came to visit me. She thought it was good and she was relieved again. I mean there are occasions when they do use the restraints,
when you do start to feel yourself falling apart,” Alan paused for a moment and said, “Maybe you have something specific to ask.”

“I have some questions that came up for me while you were talking. How do you make sense of this almost constant thought to kill yourself?”

“Uhm, I mean I feel hopeless, feeling like you don’t have a place in this world. I mean, yeah, it’s just there everyday. I would think I’d be able to—it’s just been an everyday thought for so long that I can’t help it. I mean I went through a period where I thought I was gonna jump off a building, thought about it everyday, but I never went that far. But, you know I’d walk around seeing tall things thinking, you know, how can I climb that? You know, to do that—I mean I feel like I’m such a burden on so many people that I’d rather just go over the edge and they wouldn’t have to worry about me any more. It seems like it’d be worse to worry, than it would be to just go through the grieving process for them. Sometimes, I just wouldn’t want to be here anymore as a burden. When I say that, my family gets really mad and I keep saying that. I mean and when I look back over everything I really have a lot and I just feel like I haven’t done anything with my life. It’s just a constant thought. I try to look at everything from a lot of angles and I realize when I think of suicide, I think of it as the most selfish thing any one person can do. You’re not thinking about how are these people have to grieve and stuff like that. I know why I ignore that. I know that and I think that way [anyway]. And, I like to think of myself as a Christian and you know that’s forbidden, but it’s still there. I don’t know, I wish I could just stop thinking that way. But, I try. I don’t know what else to say about that.”

“Sounds like it’s, you think it would be easier if you just weren’t around,” I said.

“I feel like I let so many people down and I would be so disappointed when I was younger. Like, here’s this kid that had a lot of potential and he played a lot of sports and he just ended up…” When Alan did not finish his thought, I made a reflection about letting people down because he had so much potential.

“I don’t know how well [I went through elementary school]. When I went through high school, I started getting really, really, really good grades. Then, I went to college and I was gonna try to make something of myself and I screwed it all up. Um, there’s people that say that I should take a look at some things that I’ve done, you know. I do have college degree. I should think of it as something I have accomplished. And, it’s just, I kind of say it’s not much of a degree, it’s just a liberal education. I had a major and did a couple of subjects and I didn’t really
think they were that difficult. I just kind of— I drank a lot of college. I’m a disappointment. I graduated with right around a 3.0 GPA, and, to me, that was not very good. I just kind of didn’t acknowledge it. I just didn’t see it as that big of an accomplishment at all.”

“What did you study?”

“History and German. I think about my time in college and I don’t have a huge opinion, because I didn’t have a major until like my junior year. Most people have 4 or 5 or 6 majors and I kept changing. So, I just had classes in it and I just decided to finish it out. I never really [was into] German, but I went to college thinking I was more of a math-science-engineering type of guy and graduating with that it’s not practical, you know there’s not a lot to do with that. You know now I have to go back.”

“Sounds like it’s hard to see yourself as successful in any way,” I said.

“Um, I have a big problem with my self-esteem and everything. Like I’ve never—I’ve worked in grocery stores and factories. You know, I’ve never actually applied for something that was actually, kind of, had to use [my skills] for it and it’s kind of a fear of failure and rejection. It’s just really hard for me to stick my head out there and see if I can do something. It would be nice to think that I [can do something] with a college education for, I mean I know that it’s still a feeling that I’m going there expecting—Like in sports the coach wants to win, but there are some coaches that play not to lose. And, the not to lose ones are kind of being held back by something than the ones that play to win. And, that’s kind of what I feel like. I don’t want to lose because I want to make sure that I can get that position, but then I don’t even try. I get to the point where I don’t need to take a chance and I miss a lot of opportunities when there isn’t a 100% chance I’ll get it. It’s like I said I try really hard to take that chance, because you don’t really know if you don’t take that chance. I still can’t do it,” Alan explained.

“Take the chance?”

“Yeah.”

“So, you almost don’t even know what the coaches who play to win are like as compared to the coaches who play not to lose?”

“I know it is something that makes sense to me, but I don’t know if that makes sense to you.”

“I don’t know if I have the whole picture, but I’m starting to.”
“I mean this applies not only to careers, but even asking girls out. I’ve never even asked a girl out and I’m 30 years old. I’ve seen it in all parts of my life. I don’t know—I didn’t want to get turned down, like I just couldn’t have. I can’t try. I don’t know what it is. It seems like if I understand all that I should be able to try, but I still don’t.”

“I mean it sounds like you actually know what’s going on, but emotionally, it’s hard to try it, it doesn’t make sense that way. Because intellectually you know what to tell yourself, but it doesn’t really do anything for you,” I reflected.

“Yeah, it’s like a lot of these classes. I understand why these coping skills should work. I just—it’s easy to hear it, but it’s so difficult for me to practice. I mean, it does bother me because if I know why it should work, and if I tried it, then I just can’t get past that point of trying it. Or to even try it.”

“Did it feel that way as a child?”

“Um, I did what I’m supposed to do. I guess as a kid, I’ve been on bikes and things like that, but there are a lot of things that I was too afraid to try and talk to someone. Somehow I just got lucky, but, I mean, I guess I can’t say I don’t take a chance with everything. I do take chances at times, when I wasn’t thinking about being afraid of trying, I don’t know. I mean, I don’t know about that part. I always have a hard time making new friends because I’m not very good at conversation and I almost always wait for someone to talk to me before I talk to them. And, I always have to think of something to say to start a conversation and I feel like the other person will not want to keep the conversation going. I don’t know what if that made sense.”

“What kind of thoughts or feelings come up when, let’s say hypothetically, you were going to go talk to a new person?” I asked.

“At first, you want to kind of watch the person and see kind of how interactive they’re going to be. Things like that. And, I’ve been here, there’s only one other person that I feel somewhat comfortable with. I mean, I think when I’m in this type of environment, I think I did maybe get a little bit better. I kind of watch to see how they’re going to react. Then, I might say hey, ‘you might not want to try this, it’s kind of against the rules.’ I mean I don’t take the high road, but I mean it happens. And, if I see them watching sports or something, I think maybe they’re a sports fan. So, I just try to watch for other people… try to find something we both like. I don’t know if I see someone come in and I would go right for it. I don’t know.”

“Do you have any close friends or close relationships with people?”
“Not really, no. I can remember like my best friend when I was six or seven, but I would always want to go to his place and I wouldn’t want him to come to my place. We moved around a lot like every few years sometimes even every year. So, we moved so much it was hard to meet new people. At schools, I could, at times, but, even then, after a few years we would move. I don’t remember any close relationships in junior high.”

“The more you say the more it sounds like there were a lots of things going on, moving around a lot, family not getting along.”

“Um, I remember we lived in this small trailer. There were only like two bedrooms, so they built a room out of ammunition boxes and always moved it around. It was like patchwork. I don’t even know, I guess we couldn’t afford to live in a place so we kept moving around. I never really lived in like a house. We lived on a base, on a post. I was there for a while. It was like three years, so it was kind of like the longest time we had stayed somewhere. Even then, I don’t remember making any kind of close friends, but I mean they weren’t all that close. And then in high school, from the day I walked in I felt removed you know. But, this one guy came up and we had a close relationship you know.” Alan described a story where a friend had betrayed him by borrowing a large sum of money. Alan needed to sell his car to have enough money to survive. However, he stayed friends with the person when he was in college.

“Sounds like he screwed you over.”

“Yeah.”

“How did you learn to trust him?”

“Well, I mean, he was my friend in high school and in college, and then I thought you know, um, maybe he’s a really good friend. I don’t know. He even started writing me personal checks that I would cash right out of my bank and they would bounce and I had all these of over-drawing type things. I don’t know—I don’t know if you would call that a pretty close friendship. I didn’t know him that well in high school, because he was older than me, but my freshman year of college, we saw each other, and we became pretty good friends. Then he went to graduate school, so I haven’t heard from him since then. I have a roommate of mine, that we became really close friends and we just spent a lot of time together. But, at this point in time, I really don’t have any close friends at all. Well this lady, my ex-girlfriend’s mother, she’s really good to me. In a way, I can’t even repay her.”

“So, you have had a girlfriend before?”
“Yeah, I’ve had a couple. I’ve had three, but I’ve never asked any of them out. It was kind of odd I mean. It was kinda hard. You know I didn’t have my first girlfriend until college. I didn’t have anyone to go to the dances with or anything like that in high school, you know, prom.”

“Sounds like you didn’t really go out much.”

“Yeah, I mean, I kind of see myself as this guy that can mix in with anybody. But, at the same time, I did feel out of place after all. I mean usually, I’m the kind of guy that people would talk to, when I said people like sports-type people, and I can just speak with all in general, but I never got even close once, except the ones I told you,” Alan explained.

“What were your romantic relationships like?”

“They were pretty good. The first two—I’m not a confrontational type of person. I don’t like getting all in it, but I don’t think the first two relationships had any type of argument in them at all. It’s just that situations and time and whatever were kind of, we’d never even broke up over a fight. I mean, we just kind of went our ways. I don’t even know how we actually ended the relationship. Now, the third one, that’s a different story, because we uh, we got in lots of arguments. That’s because I lived with her. I’d never lived with anyone before except for—well, before her I had a college roommate—but it had never been a girl, and she was pretty confrontational. I would literally try to run out of the house when she started to get mad and that made her even madder and she would chase me down in the car. I mean that’s my first love too, so it kind of sounded really weird. She’s the only person I’ve ever fallen in love with and she was kind of hot-tempered a little bit and, you know, it was pretty bad when people break up. And her mom, she did not really take any sides, but she was a shoulder to cry on—like I said she looked at me being like a son. She fed me a lot, you know she consoled me when I was crying over things,” Alan said.

“She was someone you could depend upon.”

“I just hate the fact that she was hearing her side and then she was hearing my side. She agreed with me a lot. I kind of broke up with her and she went off, like kind of went crazy. And, here I am, trying to get out as fast as I can. I was doing this for over a year and a half, just almost crying every night with her mom. She eventually moved away. I just found out, five, six months ago, she was engaged already.”

“So, you still stay pretty close with her?”
“Yeah, with the mother.”

“When did the relationship end?” I asked.

“A couple of years ago. You know it was only an eight and a half month relationship, but it’s the longest relationship I’ve ever been in, so I kind of fell hard. I pushed her away, I told her that, I was just going to hold her back and she could do a lot better, and I just pushed her away,” Alan said.

“So, you were telling her that she should break up with you.”

“Um, well, well yeah. I’d just say that I was just going to hold her back and that she could do a whole lot better, basically.”

“How did you hold her back?”

“I don’t know, she, she could have changed a lot with what she wanted to do with her career and stuff. But, you know, she was finishing college, so she had to kinda make a move, to get a degree or something. I just like—I was holding her back. I didn’t have a license or anything because of my DUIs. And, so she would leave me at home, or whatever, I just tried to move on.”

“Is that how the relationship ended?” I asked. Alan shrugged his shoulders with his eyes fixed on the floor. “Did it become too much, at some point—too hard to be that close to someone?”

“I’ve been known to have a wall. I think I’ve gotten a lot better in the last couple of years, opening up, but I just have a wall. I just kind of keep everybody kinda at arms length. I can be pretty stubborn. You know when she first kind of said, ‘No, you won’t hold me back,’ and kinda fought it, I just kept pushing it—I can’t remember what I said—but I kept pushing it. And, it was a week later and I was trying to get her back.

“You tried for a week to get her back?”

“It seemed like a week later before I tried to start getting her back. And, I tried for a little bit, it was only about a week afterwards and she had pretty much moved on. I tried for a long time.”

“How did you try?”

“Mmm, by making her dinner, trying to go over there and talking. Because when I tried to get her back it kind of, she’d get kind of mean,” Alan said with a desperate laugh. “You know, I brought her flowers, and dinners and asking to just hang out with her. What ended up
happening was she said we could get back together. Then, soon after we were back in the relationship, I kept pushing her away again, and she said, ‘There’s no point of doing this and that we should just stay friends.’ ‘Cause that’s kind of the way I pushed it, like ‘let’s just kind of stay friends.’ It was my fault, then after that I kept trying to get her back. I ended up making a mess because then I’d push her away again. I didn’t know what I was doing, I mean I’d never been in that kind of a relationship of trying to get someone back. So I don’t know.”

“So, she would say, you just wanted to stay friends and you felt to blame in all of this.”

“She didn’t take it very well. I don’t know. Her first boyfriend after that, her mom hated him. But, I don’t know about that. I mean I try to think about it and I don’t know how it would have been. I am just now getting to the point—well, it’s been a few months now and I pray for her you know and I hope she’s happy. There was a time when I thought maybe even after she moved that we could get back together. She didn’t think that way at all.”

“Can you tell me why you feel like that?”

“I mean, one time I just came back to visit her mom and stop by the house. And, it seemed like maybe this friendship type thing could work and maybe I could get back into the relationship. There were just little things I realized and just being the way she was when we were together when we were fighting there for awhile and after the break-up she was like a different person. And, there was this one night, where we went out and had a really good time—she seemed happy to be around me.”

“And, you guys were having a good time and you still didn’t want to get back together?”

“Yeah, it just kind of reinforced it. She would probably say the same thing,” Alan explained. He paused and continued, “I mean we lived together for a little bit until she went to school. I just didn’t want it to be over. I’m just not the kind of person that talks to a lot of people. But, I never knew what I was doing. I was a totally different person. They always knew what I was thinking before I passed out and I talked to that psychologist. And you know, same thing with my feelings, you know I just wanted to try and keep a straight face. I mean there were days I just kept crying, I was talking to someone about it, crying on the phone. I would just sit there and cry. You know, this wasn’t me at all, but I couldn’t help it. I couldn’t help it at all.”

I reflected what Alan had said and he responded, “When I first started talking about suicide and stuff, things were starting to get easier and easier because I had never thought that before. It was just like such a relief, a weight off my shoulders.”
“How so?” I asked.

“I don’t know like with the emotions, like being able to talk about my disorder and stuff, and, before, not being able to talk to people about it. I just kind of relate that to what happened. I was able to openly talk about these things, even though I kept crying, you know. I wish I could have kept the conversation going. I kind of felt like pity me.”

“How does that play out here?”

“Here it’s not so bad because I mean they’re here for that reason. They’re here for me to you know talk about that stuff and what’s bothering me. It appears when I talk to them. I’ve really gotten to the relationship type of thing, of trying to relate to them with my suicides and my DUls, my substance abuse. So, I get along, I mean this is just people that I work with. You know, I didn’t talk very much and then all of a sudden I’m crying in front of them all the time, so it’s different. But, here, you know I feel able to talk about that stuff and cope with it. I mean I used to have pretty good concentration and stuff, but it seemed like you know lately my concentration isn’t as good, thoughts seem to be coming out of me and I can’t remember them.”

“Has that been happening here today?” I asked.

“A little bit. Um, and, before, I mean, I know what I was talking about, but I don’t know if it’s the meds or what. Because some of them help with the lack of concentration, but I don’t know. I’m sure some of them probably have side effects, so that’s something I might have. It’s confusing.”

“It seems like it’s difficult or, even frightening, to talk about the past?”

“I think I was worried to bring it up because of how they would react. How my parents would react and, you know, my brother and my sister, I didn’t know if they would understand. Like, even now, when my dad, I’ve called him here a couple of times, he doesn’t understand, he doesn’t believe—and this is the way my mom had it too—just taking all of these pills and the side-effects being worse than what the pills are supposed to be treating. And, you know, that’s the way I think about them. So, I’m not quite sure if my dad understands what’s going on. I mean I have kind of changed my opinion a little bit, that I do need these meds, even though I don’t think I’ve got the right ones yet. And, my mom’s come around too. She found out, well she’s met people that she’s worked with that are like bipolar and things like that and she sees how the meds can help them. So, I think you know she progressively, she’s gotten more and more understanding, but, dad, I don’t think he’s done that yet. I mean, he thinks I just need to be
around people that are going to support me and just be around the family type, you know, not even doctors and therapists stuff. My mom is trying to come around seeing things like the meds, state hospital environments isn’t as bad as she thought. I think she’s gradually coming to an understanding. That’s why I wouldn’t even know how to approach them or how to tell them about suicide, you know what I mean, that it happened.”

“So, your dad thinks that if you’re just around people that will be supportive, like friends and family you will be better off?”

“I think so, and he doesn’t like—I kind of have a hard time picking up all these meds and they’re just not working for me. But, then they always say, think of a diabetic, they have meds to go on. My dad’s a diabetic now, he has to take a shot a couple times a day, but those worksheets always say if you’re a diabetic you have to do this. And, I don’t know I never actually said it to my dad, but I wonder what he would think if it’s a lot like you being a diabetic. I don’t know how to do that, but I’m also not sure he would take that side yet. I’m not sure if I am taking the right ones yet. I’ve gotten some negative side effects from a couple. Well, there’s a couple for the sleeping I take. I’m sleeping more. But, as far as feeling, I feel that I am worthless, I don’t know how that’s supposed to change because I think that way. I went from feeling helpless to not feeling able to do something with my life. I know that the pills are just part of it, but you also need to change from within. But, I just don’t think pills are everything, but I do think they have that kind of effect on me. Some people say they can tell from just hearing me on the phone. They say I sound livelier and not as negative, so they can see it, but I can’t and that’s frustrating. I still don’t see it and I’ve been on a lot of meds in a lot of different hospitals, well not really that many hospitals, but twice and this one. But, I’ve been on a lot of meds. I know it’s all trial and error and you just have to find the right combination, but it’s hard to wait around and wait for an impact—something that feels different. And I don’t think it works that way, but that’s what I feel like, I’m just waiting for it.”

“So, it doesn’t sound like you’ve changed your perspective,” I offered.

“I mean I guess like the sleeping ones, but that’s different from the anti-psychotics and anti-depressants and all that kind of stuff. I can see that I’m sleeping more and I can see that I don’t fidget as much, but the thoughts and the feelings I have are still there.”

I asked Alan what would be helpful and we discussed his plans to move closer to his mother. He was concerned, however, with “relapsing” after a period of doing better. After each
hospitalization, he enjoyed a period of time where he felt better until he would “hit a wall” and begin to experience thoughts of suicide and hopelessness. He did look forward to reconnecting with his mother and hearing her side of the events in his past. He also was very excited to connect to his cultural heritage. He was concerned with his father’s reaction, as he was not aware of Alan’s plans. In the last part of the interview, we discussed his difficulty in talking to his father about his plans. Alan described how he often took responsibility for the emotional well being of his often fragmented and disconnected family. For instance, there was a point where many of the family members were not talking with one another. Alan thought that if he killed himself, he would bring his family together. Alan described how he often felt angry with himself as opposed to others and we discussed this pattern in relation to his suicide attempts.

Preparation of Experiential Constructivist Diagnosis. In this section, I will be providing the diagnosis I presented to Alan juxtaposed with a description of how the diagnosis group constructed the EPCP diagnosis. Throughout the diagnosis, the research group gave Alan some examples that provided a basis for our decisions about his experiential constructivist diagnosis. The group decided that Alan struggled primarily with self-other constancy. While he appeared have a solid sense of self-other permanence some of the time, we thought there may have been times when it was difficult for him to have a sense of self-other permanence. On axis II, the group concluded that Alan avoided dependencies. On axis III, we concluded that Alan primarily struggled with discrimination, responsibility, commitment, openness and forgiveness.

Because Alan struggled primarily with self-other constancy, we began his diagnosis describing his struggles with constancy and the impact of structural arrests:

The intense struggles you have been experiencing may be understood in relation to the injuries you experienced at an early age. These injuries make it difficult to maintain a solid and stable sense of self—a self that you could use to engage others and the world. For all of us, early understandings of the self are fragile and delicate. However, with reliable and consistent nurturing, these understandings become more solid and stable. Unfortunately, the people closest to you often acted in unpredictable ways, making it difficult for you to develop a more stable sense of self. For example, at times, it seems that you see yourself as accepting and caring and feel like you deserve the attention and love of another person. At other times, it seems as though you see yourself negatively, feel bad about yourself and not deserving of the attention and love of another person.
Because Alan seemed to struggle with constancy, we wanted to convey that it was important for Alan to remain aware and integrate these parts of himself.

We then provided an example of experiences that may have contributed to Alan’s struggles with self-other constancy:

It appears that your biological parents had difficulties sharing their experience with you. In turn, this seems to have made it difficult for you to explore and understand your own experience. An example of this may be when your parents divorced. The difficulties that they were having in their marriage may have been hidden from you. You describe this event almost as if your mother had suddenly disappeared. Another example may be the entrance of your stepmother into your life. Your father brought another person into your life with little explanation. Soon after she arrived, she was known to you as “Mom.” The entrance of another woman into your life, a woman that was supposed to take the role of mother and caregiver, is a very important event in a child's life. As your father did little in the way of explaining this to you, this must have been confusing and possibly frightening. You describe these important events as if you were not really there. Because your caregivers did little to explain these confusing but meaningful events to you, it seems as though you felt invisible at these confusing times.

We deliberately wrote this section in a way that implied Alan also struggled with self-other permanence at times. The research group felt that Alan may have struggled with self-other permanence when he was more distressed. For example, Alan had difficulty connecting his inner and outer experience when feeling suicidal, indicating a struggle with self-other permanence. Alan did not appear to have a solid foundation to make sense of his experience. Because he did not have a solid foundation, he struggled to make sense of his actions and they appeared alien to him.

We continued the EPCP diagnosis with a concrete hypothesis as to why Alan struggled with self-other constancy:

When parents do not explain why events are happening, children need to find ways to make sense of these events. Children could understand such events in two major ways. They could feel that they were the cause of these events and see themselves as bad and their parents as correct. On the other hand, children can see their parents as bad or at fault and see themselves as good. But, this is a difficult perspective to take (finding fault
with our parents) as we are physically and psychologically dependent upon them during the early years of our lives.

We hypothesized that Alan had difficult negotiating responsibility because parts of himself felt disconnected from one another. Alan often struggled to connect events to his experiences. We thought it would important to provide a context for this struggle. Therefore, we continued to describe his struggles against the backdrop of early relational injuries:

This seems to reflect how you understood your caregivers' actions. At times, you may have felt you deserved more support from your parents when they acted in ways that did not feel correct for you. In other words, it seems as though you felt good about yourself and felt that there was something wrong in your environment. At other times, it seems as though you felt that you were the cause of the events (divorce, feeling last in your family) in your environment. This perspective may have made you feel bad at yourself. This perspective may have also added to your feeling of being invisible. Feeling invisible may have felt better and safer than feeling that you were to blame for these events. Integrating these two perspectives may make you feel more stable and less invisible, as you would be able to experience your self and others in a more consistent way.

Again, feeling invisible implied a struggle with self-other constancy. When a person is visible, others can see him or her and infer some continuity over time. When others might see parts of Alan that are threatening, he withdrew into invisibility. Therefore, we wanted to convey that Alan may find it difficult for others to see his constructions of the world. We then moved to describing how early relational injuries may function in the present.

Currently, it seems as though you move from one perspective to the other without being aware of it. For example, you mentioned not wanting to place the blame for your struggles on your stepmother. While not blaming her may be a good decision, you also seem to be aware of the ways she affected your current struggles. Her sudden entrance into your life and the ways she made you feel last in the family affect you currently. At times, you may have even been angry with your stepmother, but you may be afraid to express or experience this anger. It may be helpful for you to be able to understand the impact your stepmother had on your current struggles (without blaming her) and be angry at her for the way you were treated.
With this example, we wanted to convey that it was important for Alan to understand how he construed events.

We concluded our discussion of his struggles with self-other constancy by connecting this concept to his numerous suicide attempts:

Integrating these two perspectives would make you feel more stable, secure and present in your experiences. As you described parts of your life, it seemed as though you struggled to connect your own inner experience to the events of your environment. Also, it often sounded as though your moods and actions were disconnected from you. Put differently, your motivations and beliefs did not seem to play a part in how you thought of yourself. For example, you described feeling confused about your suicide attempts and almost described feeling suicidal for no reason. Connecting your actions and your motivations may help make sense of these painful experiences.

We continued Alan’s diagnosis with a description of the ways he avoided dependencies:

As you have had difficulty feeling consistent and stable, it seems difficult for you to enter into relationships. Because you were not able to reliably depend upon and trust your parents, it is difficult for you to put yourself in a position to depend on others. You describe avoiding entering into relationships with others, as others often feel threatening. You also seem to distance yourself from the people that you have had relationships with. For example, you described telling your last girlfriend that she could do better than you and should leave. This seems to have distanced you from her and called for the end of the relationship. But, you describe this being the first real love of your life. As you became closer with her, this seemed threatening and confusing for you and telling her these things may have been a way to distance yourself from her. You also describe physically leaving the house when arguments and interactions became too intense. While it seems that you cared for her, it was also difficult for you to feel stable and safe in this relationship. Relationships can be awe-inspiring experiences, as others can confirm us in profound ways. At the same time, relationships can be terrifying, as others have the ability to reject and invalidate us as they become closer to us. It seems as though you fear being rejected and it may be feel safer to avoid relationships altogether. While this feels safer, it keeps you from having meaningful relationships with others.
As Alan both physically and psychologically distanced himself from relationships, it was important to convey that relationships often felt very threatening to Alan, as depending on others had been very dangerous in his life.

Because of his struggles in dispersing his dependencies, Alan often struggled with discrimination:

Managing this tension seems difficult. Discriminating between those where that risk of injury is too high versus those where the risk feels more acceptable can be a struggle. It appears that most potential relationships feel risky and any difference between you and an other is enough for you to avoid entering into a relationship with that person.

We continued our diagnosis with a description of the ways Alan struggled with responsibility. Alan struggled to make sense of the ways others treated him. He found it difficult to realize the impact of his past on his present life. Thus, Alan often had difficulty negotiating responsibility.

As mentioned above, it may be useful to understand the connections between your inner experience (your feelings, thoughts, motivations) and your actions, as it often seems as though you feel controlled by your emotions and this leaves you feeling powerless. At times, you take all the responsibility for your struggles. For example, you described thinking that if you committed suicide, it would be easier for your family than to worry about you. At other times, it seems that you are aware that you are not fully responsible for your current struggles and other people played a role in who you are today.

Negotiating this tension may allow you to feel less threatened and confused in relationships.

His difficulties in relationships often made it difficult for Alan to commit to a relationship:

Additionally, because of these struggles, it seems difficult for you to remain in and commit to relationships. When you become closer to someone, the realization that an other could hurt you may be too much too bear. It is difficult to manage when one should leave a relationship and when one should stay in a relationship. When relationships only last for a short period of time, it is difficult for us to figure out if the relationship is worth the potential risk.
As most relationships felt risky to Alan, he felt increasingly threatened as relationships deepened. Alan’s experience of relational threat also led to struggles with openness:

In all relationships, people disagree and feel hurt by their partner. This is a necessary part of relationships, as understanding these disagreements helps the relationship to grow. In order to grow, however, we need to be able to change our understandings of ourselves and the other person. Without being open to change, the pain that exists in relationships may be too much for you to bear and it may be easier to end the relationship altogether.

We concluded our diagnosis with a description of forgiveness:

Understanding how past injuries affect you currently may be an important part of understanding who you are presently. When psychological injuries occur in past relationships, it becomes difficult to leave these injuries in the past. Understanding new relationships in terms of old relationships is useful, but we often can bring the hurt from past relationships into our current ones. It may be useful for you to make sense of how you were hurt in past relationships in order to be aware of how they affect your current relationships and your current struggles. You mentioned wanting to reconnect with your mother to find out two important pieces of your history. First, you want to figure out your personal history by understanding more about how she was treated in her relationship to your father. This would help you make sense of you felt at those times. Second, you want to learn more about your cultural heritage and connect to those parts of yourself. Understanding your past seems to be an important part of figuring out your present life.

By ending with forgiveness, we hoped to provide some ways for Alan to feel more connected to his past while simultaneously feel more present, stable and consistent.

While I have provided the entire description of the diagnosis that I presented to Alan, I will provide the unbroken description to facilitate comparison of the two diagnoses for the reader. I provided the following description to Alan:

The intense struggles you have been experiencing may be understood in relation to the injuries you experienced at an early age. These injuries make it difficult to maintain a solid and stable sense of self—a self that you could use to engage others and the world. For all of us, early understandings of the self are fragile and delicate. However, with reliable and consistent nurturing, these understandings become more solid
and stable. Unfortunately, the people closest to you often acted in unpredictable ways, making it difficult for you to develop a more stable sense of self. For example, at times, it seems that you see yourself as accepting and caring and feel like you deserve the attention and love of another person. At other times, it seems as though you see yourself negatively, feel bad about yourself and not deserving of the attention and love of another person.

It appears that your biological parents had difficulties sharing their experience with you. In turn, this seems to have made it difficult for you to explore and understand your own experience. An example of this may be when your parents divorced. The difficulties that they were having in their marriage may have been hidden from you. You describe this event almost as if your mother had suddenly disappeared. Another example may be the entrance of your stepmother into your life. Your father brought another person into your life with little explanation. Soon after she arrived, she was known to you as “Mom.” The entrance of another woman into your life, a woman that was supposed to take the role of mother and caregiver, is a very important event in a child's life. As your father did little in the way of explaining this to you, this must have been confusing and possibly frightening. You describe these important events as if you were not really there. Because your caregivers did little to explain these confusing but meaningful events to you, it seems as though you felt invisible at these confusing times.

When parents do not explain why events are happening, children need to find ways to make sense of these events. Children could understand such events in two major ways. They could feel that they were the cause of these events and see themselves as bad and their parents as correct. On the other hand, children can see their parents as bad or at fault and see themselves as good. But, this is a difficult perspective to take (finding fault with our parents) as we are physically and psychologically dependent upon them during the early years of our lives.

This seems to reflect how you understood your caregivers' actions. At times, you may have felt you deserved more support from your parents when they acted in ways that did not feel correct for you. In other words, it seems as though you felt good about yourself and felt that there was something wrong in your environment. At other times, it seems as though you felt that you were the cause of the events (divorce, feeling last in
your family) in your environment. This perspective may have made you feel bad at
yourself. This perspective may have also added to your feeling of being invisible.
Feeling invisible may have felt better and safer than feeling that you were to blame for
these events. Integrating these two perspectives may make you feel more stable and less
invisible, as you would be able to experience your self and others in a more consistent
way.

Currently, it seems as though you move from one perspective to the other without
being aware of it. For example, you mentioned not wanting to place the blame for your
struggles on your stepmother. While not blaming her may be a good decision, you also
seem to be aware of the ways she affected your current struggles. Her sudden entrance
into your life and the ways she made you feel last in the family affect you currently. At
times, you may have even been angry with your stepmother, but you may be afraid to
express or experience this anger. It may be helpful for you to be able to understand the
impact your stepmother had on your current struggles (without blaming her) and be angry
at her for the way you were treated.

Integrating these two perspectives would make you feel more stable, secure and
present in your experiences. As you described parts of your life, it seemed as though you
struggled to connect your own inner experience to the events of your environment. Also,
it often sounded as though your moods and actions were disconnected from you. Put
differently, your motivations and beliefs did not seem to play a part in how you thought
of yourself. For example, you described feeling confused about your suicide attempts
and almost described feeling suicidal for no reason. Connecting your actions and your
motivations may help make sense of these painful experiences.

As you have had difficulty feeling consistent and stable, it seems difficult for you
to enter into relationships. Because you were not able to reliably depend upon and trust
your parents, it is difficult for you to put yourself in a position to depend on others. You
describe avoiding entering into relationships with others, as others often feel threatening.
You also seem to distance yourself from the people that you have had relationships with.
For example, you described telling your last girlfriend that she could do better than you
and should leave. This seems to have distanced you from her and called for the end of
the relationship. But, you describe this being the first real love of your life. As you
became closer with her, this seemed threatening and confusing for you and telling her these things may have been a way to distance yourself from her. You also describe physically leaving the house when arguments and interactions became too intense. While it seems that you cared for her, it was also difficult for you to feel stable and safe in this relationship. Relationships can be awe-inspiring experiences, as others can confirm us in profound ways. At the same time, relationships can be terrifying, as others have the ability to reject and invalidate us as they become closer to us. It seems as though you fear being rejected and it may be feel safer to avoid relationships altogether. While this feels safer, it keeps you from having meaningful relationships with others.

Managing this tension seems difficult. Discriminating between those where that risk of injury is too high versus those where the risk feels more acceptable can be a struggle. It appears that most potential relationships feel risky and any difference between you and an other is enough for you to avoid entering into a relationship with that person.

As mentioned above, it may be useful to understand the connections between your inner experience (your feelings, thoughts, motivations) and your actions, as it often seems as though you feel controlled by your emotions and this leaves you feeling powerless. At times, you take all the responsibility for your struggles. For example, you described thinking that if you committed suicide, it would be easier for your family than to worry about you. At other times, it seems that you are aware that you are not fully responsible for your current struggles and other people played a role in who you are today. Negotiating this tension may allow you to feel less threatened and confused in relationships.

Additionally, because of these struggles, it seems difficult for you to remain in and commit to relationships. When you become closer to someone, the realization that an other could hurt you may be too much too bear. It is difficult to manage when one should leave a relationship and when one should stay in a relationship. When relationships only last for a short period of time, it is difficult for us to figure out if the relationship is worth the potential risk.

In all relationships, people disagree and feel hurt by their partner. This is a necessary part of relationships, as understanding these disagreements helps the
relationship to grow. In order to grow, however, we need to be able to change our understandings of ourselves and the other person. Without being open to change, the pain that exists in relationships may be too much for you to bear and it may be easier to end the relationship altogether.

Understanding how past injuries affect you currently may be an important part of understanding who you are presently. When psychological injuries occur in past relationships, it becomes difficult to leave these injuries in the past. Understanding new relationships in terms of old relationships is useful, but we often can bring the hurt from past relationships into our current ones. It may be useful for you to make sense of how you were hurt in past relationships in order to be aware of how they affect your current relationships and your current struggles. You mentioned wanting to reconnect with your mother to find out two important pieces of your history. First, you want to figure out your personal history by understanding more about how she was treated in her relationship to your father. This would help you make sense of you felt at those times. Second, you want to learn more about your cultural heritage and connect to those parts of yourself. Understanding your past seems to be an important part of figuring out your present life.

*Validation of the DSM Diagnosis.* Alan’s therapist diagnosed him with Avoidant Personality Disorder and based his treatment on that diagnosis. Alan had a long history of diagnoses including Bipolar Disorder, Major Depression, Recurrent, Borderline Personality Disorder and Obsessive-Compulsive Personality Disorder. The research group agreed with the diagnosis and we used the DSM description of avoidant personality disorder.

One must meet at least four of following seven symptoms to be diagnosed with Avoidant Personality Disorder (the ones we think he met are in bold): (1) avoidance of occupational activities that involve significant interpersonal contact; (2) unwillingness to get involved with people unless certain of being liked (e.g., only approaching patients watching sports); (3) show restraint within intimate relationships because of the fear of being shamed or ridiculed (e.g., his description of his last romantic relationship); (4) preoccupation with being criticized or rejected in social situation (e.g., descriptions of interactions with peers); (5) inhibition in new interpersonal situations because of feelings of inadequacy (e.g., his descriptions of his participation in hospital activities); (6) views self as socially inept, personally unappealing, or
inferior to others (e.g., see his disparaging comments about himself in light of accomplishments); (7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing. I have provided one example of each criterion in parenthesis.

I presented the following description of avoidant personality disorder to Alan:

Individuals with struggles similar to yours are characterized in the following fashion. The essential feature of such struggles is a pervasive pattern of avoiding social situations, feelings of inadequacy, and being overly sensitive to negative evaluation. This begins by early adulthood and is present in a variety of contexts.

Individuals with such struggles avoid work or school activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection. Offers of job promotions may be declined because the new responsibilities might result in criticism from co-workers. These individuals avoid making new friends unless they are certain they will be liked and accepted without criticism. Until they pass stringent tests proving the contrary other people are assumed to be critical and disapproving. Individuals with such struggles will not join in group activities unless there are repeated and generous offers of support and nurturance. Interpersonal intimacy is often difficult for these individuals, although they are able to establish intimate relationships when there is assurance of uncritical acceptance. They may act with restraint, have difficulty talking about themselves, and withhold intimate feelings for fear of being exposed, ridiculed, or shamed.

Because individuals with such struggles are preoccupied with being criticized or rejected in social situations, they may have a markedly low threshold for detecting such reactions. If someone is even slightly disapproving or critical, they may feel extremely hurt. They tend to be shy, quiet, inhibited, and “invisible” because of the fear that any attention would be degrading or rejecting. They expect that no matter what they say, others will see it as “wrong,” and so they may say nothing at all. They react strongly to subtle cues that are suggestive of mockery or derision. Despite their longing to be active participants in social life, they fear placing their welfare in the hands of others. Individuals with such struggles are inhibited in new interpersonal situations because they feel inadequate and have low self-esteem. Doubts concerning social competence and personal appeal become especially manifest in settings involving interactions with
strangers. These individuals believe themselves to be socially inept, personally unappealing, or inferior to others. They are unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing. They are prone to exaggerate the potential dangers of ordinary situations, and a restricted lifestyle may result from their need for certainty and security. For example, they may avoid social situations and have a constricted routine for daily activities. Marginal somatic (physical) symptoms or other problems may become the reason for avoiding new activities.

Individuals with such struggles often vigilantly appraise the movements and expressions of those with whom they come into contact. Their fearful and tense demeanor may elicit ridicule and derision from others, which in turn confirms their self-doubts. They are very anxious about the possibility that they will react to criticism with blushing or crying. They are described by others as being “shy,” “timid,” “lonely,” and “isolated.” The major problems associated with these struggles occur in social and occupational functioning. The low-self esteem and hypersensitivity to rejection are associated with restricted interpersonal contacts. These individuals may become relatively isolated and usually do not have a large social support network that can help them weather crises. They desire affection and acceptance and may fantasize about idealized relationships with others. The avoidant behaviors can also adversely affect occupational functions because these individuals try to avoid the types of social situations that may be important for meeting the basic demands of the job or advancement.

The avoidant behavior often starts in infancy or childhood with shyness, isolation and fear of strangers and new situations. Although shyness in childhood is common precursor of developing such struggles, in most individuals it tends to gradually lessen as they get older. In contrast, individuals who go on to develop such struggles may become increasingly shy and avoidant during adolescence and early adulthood, when social relationships with new people become especially important. There is some evidence that in adults such struggles tend to become less evident or to remit with age.

*Presentation of DSM Diagnosis.* Before presenting the DSM diagnosis to Alan, I asked him about his personal theory of psychological struggles.

“Well I know that, you mean their method of how they—I can’t think of the right word,” Alan said and paused.
“Understand, diagnose, assess?” I offered.

“Have I given any thought to how the therapist diagnosed me?”

“No, I'm more talking about your own personal theory of psychological struggles or psychiatric struggles. Have you given it any thought?”

“Well, I guess, you know, it’s been a lifelong battle for me to deal with things. I look back on it and I think there are no grounds. I don't know why I started it. It just added on and on and on and I just kept it all in, and then I’d go through many nights and somehow find my way back to that original struggle,” Alan paused before suddenly asking, “And, I mean—am I going in the right direction that you are talking about?” His choice to check in with me reflected uncertainty on his part, as his words appeared to be contradictory. For instance, he expressed some confusion at the beginning of this passage, but then remarked he has spent many nights returning to “that original struggle,” presumably his tumultuous relationships with caregivers.

“Yes,” I responded.

“I mean I try to listen in a group setting, like we have here. I try to listen to what they’ve dealt with and everything like that and I can understand where they come from. And, when I think about myself and I think there wasn’t any traumatic events or I don’t even know why I have such a problem—I guess that’s what I'm trying to say it’s difficult, you know, ‘cause I can understand all the coping skills they are teaching us to use. And, I try to use them and they are very hard to use, even though they sound simple. They seem simple, but those are kind of hard ‘cause I need to figure out why I do the things that I do, like why do I immediately go to the worst case scenario and things like that.” Alan has a tenuous relationship with his past and has trouble construing the experiences of his past as “traumatic” or impacting his present life in any way. It also seems difficult for Alan to employ the treatment provided by the hospital, techniques for distancing oneself from painful or troublesome emotions, as they further distanced him from the past.

“So, it’s hard to figure out how to use the tools they give you,” I said attempting to reflect the difficulty Alan had in changing.

“Yeah, you gotta use them all the time and it seems like if I try to use them it’s really hard to keep building on that, because it takes one bad thing and then it’s all bad again you know.”
“It’s very confusing to figure it all out over the years,” I replied, moving back to Alan’s experience of his life.

“Yeah, in the first part of it, I thought I did know what it was and I thought I worked through it. And, these past few years I kinda found out that maybe it developed into different things. At first, whatever was wrong with me got back to my dad somehow and I found a way to do—I don’t know why I did that and somehow get it back to him,” Alan said, appearing to identify the “the original struggle” he mentioned earlier in the interview.

“Can you give an example?” I asked, hoping to understand Alan’s words better.

Alan explained, “Like if I'm obsessing or getting really depressed about something, and I start to feel down and I start to cry—I don't know it might not have been connected at all. It just—I just start there and end up in this other place.

“To your relationship with him?”

“Yeah.”

I moved to my next question of this section. “What do you think the role of therapists should be?”

“Like my therapist here, he doesn’t beat around the bush, and I think that’s better. I think they should be able to you know if they are going to decide to diagnose you—someone that can teach you tools and you know sometimes they may not be able to help the past, but, hopefully, in the future, you can learn to learn to use those tools to keep from creating that kind of path. I think that’s kind of—I don't know—I mean a whole lot more. Sometimes they just talk to make you feel better and things like that. And, that might be ok for a while, but when it gets to a certain point you just want to hear what you can do, what can I do to keep from doing some of those things. I think the most important thing though is—I think in the past—you look at different psychologists or therapists and you bring up the past and they somehow you know fix it for you that way, but I don’t see it that way at all. I just see that hopefully they can give you the tools to try to live a better life,” Alan said. Alan’s earlier confusion arises here as a fear of his past. It appeared that thinking of his past was itself a traumatic event for Alan. Even though he continues to connect his struggles to his past on an experiential level, Alan seems to fear and devalue the role of his own experience in his construing of his present life.

I focused on Alan’s more conscious experience of his struggles, attempting to minimize my disagreement with his construction of events. “So, you would want them to show you some
things, it sounds like you are saying that they not going to fix the problems, but they can give you the tools to help.”

“Yeah, ‘cause I think ultimately to fix the problem, I guess you would have to do it yourself, I mean, and I might not be able to fix that stuff anyways, the stuff in the past. I’m the worst at dwelling in the past and considering myself in the future. I can’t seem to ever be in the moment a lot of times.” As Alan would explain later, he seemed to have little hope in making sense of his life in enough of way to live a meaningful life.

“Do you focus on the past and worry about the future?” I asked.

“Yeah, I go to the DBT class. There’s a lot of reading about things you can do to keep yourself in the moment, and this is going to sound really cynical, but you know they work for the moment, and if it’s just the moment that you get, I guess that’s at least some progress,” Alan explained.

“Thanks. Why don’t we get started with the first one? If there are any terms or concepts that you do not understand, please let me know.

Alan took some time and read the DSM diagnosis. “Sounds like me.”

“Do you have any questions about it?”

“No, it sounds a lot like I am,” Alan paused and asked, “So this is basically a summary and the other two are the different diagnoses.”

“No, this is the first one, then I have a second one for you too.”

“Okay, because it didn’t mention avoidant personality disorder, it mentioned avoidant.”

“You said I mentioned the diagnosis,” I said, as I misheard Alan and took much care to remove the label from the DSM description.

“I saw avoidant. I mean it’s fine with me. I’ve been diagnosed many times. I don’t think it actually mentioned, yeah, you only wrote avoidant behaviors.”

“Well, I used more of the description than the label, but if you want to talk about the label afterwards we can do that too.”

“Yeah, this was fine. This was fine. It described me in a lot of ways. Everyway I mean. I was thinking about the childhood—it says something like such struggles often begin in infancy or childhood. They really can’t do anything about infancy, I mean,” Alan paused and referred to the diagnosis. He continued, “Avoidant behavior often starts in infancy or childhood. Yeah, okay, I mean I understand that as persons got older it’s not that difficult for them to get better,
but with people like me, those characteristics get worse. But this is basically me.” Alan took an uncharacteristic look directly at me and tried to hand the diagnosis back to me, signaling that he was done; a reflection of his discomfort with discussing himself.

“Hold on to that—I have a few more questions before we move on. So, anymore additional thoughts about this one.”

“I mean good description—I mean all the way. As far as relationships…and jobs and other situations and kind of the social things, I mean there are times when I can be kind of social. I always feel like, I always find a way to seem not normal.” He communicated that the diagnosis was accurate with the caveat that he was able to be social at certain times.

“How does it describe your strength’s and weaknesses?” I asked.

“You’re asking me, does this play on certain weaknesses? Well, I noticed a lot of it says “struggles” so those are weakness I think. I mean yeah, despite me wanting to be active…you know, I wanted to be able to get in a relationship and be able to take a job—and you know applying for a job would be difficult because when I get to that point I think, ‘Ah, I can’t do that.’ So, there’s the longing to do that kinda stuff.”

“So, even though you want to do something, it’s hard.”

“The struggles, yeah. I mean it’s hard, it’s hard with me. I mean I don’t know what…you have to have. But, that just describes part of it. For me, I don’t see that many positive things about me, but I struggle.” While Alan stated that the diagnosis was not complete in that it just described his weaknesses, he seemed comfortable with it as he felt he did not have many positive attributes.

I asked my next question: “How does this diagnosis help you understand yourself or see yourself in the future?”

“When I see it, it’s…a lot about how I progressed that way, and, at the end there, it does say that these [characteristics] become less evident. I hope that happens. I hope—you know by the age now—I should be able to—I mean, I guess maybe it’s not that old, but to be—I would think I’d start turning the corner at some point. What was the question again?”

“How does this help you—”

“There’s some hope. I mean, it says that usually people get better, and maybe, at some point, none of us will need meds, pretty much all of it does, some of it medication, some of it therapy, but I hope that at some point I can turn the corner and start changing this, my outlook on
all this. And start becoming more confident enough to do these things like get involved in social type activities and taking a job. Am I answering it pretty clearly?”

“So, in a way it gives you hope. It allows you to think of personal change. Some of the things you’re pointing out from the diagnosis is that it says you can get better. How would hearing this at the beginning of therapy affect your therapy?”

“After hearing this? If this is the first thing I listened to before session?” Alan asked.

“Let’s say, you were starting with a therapist and this was the first thing that you two talked about. How would you see the therapy progress?”

“Well, if this was my first session and this is what you gave me, I would think that the therapist would know—that they can write something like this, would let me know that the therapist has a bit of an idea of what I am going through.”

“Like the two of you are on the same page.”

“Yeah.”

“You would feel understood,” I asked.

“Yeah.”

“Do you feel comfortable with this diagnosis being given to a third party like staff or insurance companies or just other people?”

“Yeah, I mean I would sign off on the confidentiality thing. I wouldn’t have a problem with it going to a third party.”

“The next set of questions, I want to do a little exercise. I would like you to make up an imaginary therapist in your head, not someone you’ve seen in the past. So, you haven’t met this therapist face-to-face, but all you knew was that this is the way they understood you. What would your thoughts be about that therapist?”

“I think they would have a pretty good hold on who I am, which would mean that they would have a good—they’d know how to approach me with the therapy.”

“So you feel understood. It sounds like you would feel comfortable with it,” I offered.

Alan’s responses to my last few questions left me with the impression that the diagnosis did fit his experience but was limited in certain ways because of his use of so many qualifying words.

“Yeah. I think so.”

“Do you think the therapist would trust your experience of your struggles?”

“Yeah. I think it’s—yeah, I would trust them,” Alan replied.
“How do you think the therapist sees your ability to change using this?”

“I think they could see that I could improve. It mentions the struggles at the beginning and end of each paragraph. In some of the paragraphs, they could see a place for improvement,” Alan said, communicating that a therapist would be able to find a place for him to improve in light of the struggles.

“Would a therapist using this understanding be effective for you?”

“Mhm, yeah.”

“Would you be able to trust, we touched on this before, but would you trust this therapist, if this is how they were seeing you.”

“Yeah. I think they have a good idea. I mean they would know where I was coming from and I would trust them if they knew this and I would feel comfortable I think. If they help me you know,” Alan said. It seemed that Alan would trust this therapist if he saw himself improving in some way.

“Is this therapist limited in his or her understanding of you in any way?”

“It’s that, there’s a lot of stuff wrong,” Alan said, but did not elaborate any further.

“Any other thoughts before we move to the second one?”

“No, I liked it. I don’t know what else to say. I think it’s a good interpretation and everything. I mean it’s right now, it kind of sucks, but that’s the way I am, so—”

“It kind of sucks?” I asked, a bit surprised by Alan’s choice of words.

“That’s what you said, I remember like how you worded the last question. Right at the end if I was okay with it. It’s not that you were bent selling this or anything. I was just disappointed in myself because that’s the way I am. Does that make sense? Not disliking what you put down, it’s just the fact that I am that way,” Alan explained. Because Alan seemed to believe that I intended to “sell” the diagnosis, he may have been uncomfortable critiquing it. In contrast to his perceptions, I had little desire to “sell” the DSM diagnosis. In fact, I was concerned that I was too biased against the DSM diagnosis, especially in his case, as Alan was the only participant that seemed to endorse the DSM diagnosis.

“It’s not actually anything that’s written down, it’s more about why did I turn out this way?” I said, attempting to reflect Alan’s experience of himself in relation to the diagnosis.

“Yeah, yeah. I mean I think, I could have been a lot more. I had a lot of potential. I kind of fell through. I guess a lot of it is that, I had such low self-esteem that I allowed myself to fall
through. So, I think, it’s my fault. I just think I could have done a lot of things that could have changed that. I feared a lot of things and I was scared of how things,” Alan paused and seemed to discontinue his thought.

“So, there’s a lot in there, not only the fear of failing, but also—” I began before Alan continued.

“Yeah, a lot of things: a job, relationships, all that kind of stuff. And just, you know, I guess when I got ready to finally do something at the last second I would completely back out or whatever. I regret doing that.”

*Presentation of Experiential Constructivist Diagnosis.* After Alan read the experiential constructivist diagnosis, I asked if he had any questions. Alan responded, “No. Right away you can tell the difference. Neither one of them is wrong. I just felt like that one [DSM diagnosis] was more objective, precise, summary-type thing, this one is, it seemed like it was more subjective and it used a lot of examples.”

“Can you tell me a little more about the subjective aspect you’re referring to?”

“Well, uh maybe not subjective. I guess it kind of feels that way when you see the word “you” a lot. The way that “you” are doing this or that. Maybe not so much subjective,” Alan explained.

“More personal?” I offered.

“Yeah, that’s probably a better word. And, not that this one’s any worse or any better, they’re both really accurate. But, yeah, I think that word personal makes the big difference.”

Alan seemed to be equating each diagnosis in terms of accuracy, but seemed to be focused on the idiographic nature of the experiential constructivist diagnosis.

“Is it just the use of personal examples?” I asked.

“Yeah I think so.

“So, any initial thoughts.”

“Again, I think just like the other one, it’s pretty accurate, or really accurate. Uh, it just backed it up with the whole part earlier in the discussion. You know, there are some really good points in here about how, you know, about how my parents did things that could kind of affect me. The other examples about my stepmother are also good,” Alan explained. Alan seemed to resonate with the description of his caregivers’ actions.

“How does this one describe your strengths and weaknesses?”
“I think, you showed the things that are meaningful to me and what is important to me. Kind of like—I think what I’m trying to say is like, you said what I said, what I kind of want to do, what’s important to me, like my culture and knowing about my mother and me and my dad and the cultural heritage and things like that. Well, I think mostly it’s just a description…like you know I really think that there weren’t any positives and negatives…you describe, like how I looked at things. And, I didn’t see that really as a strength or weakness, but more like who I am. And I don’t know if I’m making any sense, I don’t know. I found it appropriate. I mean I don’t really see. I just see like you explaining—you know what I mean?”

“Maybe strengths and weakness isn’t accurate, but does talk about how you see the world.”

“Yeah. How I deal with things, how those thoughts disturbed me. I know that now. For awhile, that’s just how I thought, how and what I believed,” Alan responded. Rather than strengths or weaknesses (or positive and negative character attributes), Alan felt the diagnosis described how he experienced others and the world. He also implied that he had become more flexible over time and saw his thoughts as one way of understanding his reality.

“Your thoughts were disturbing?” I asked, as I did not fully understand what he had meant.

“Yeah, I understand that. Some of these thoughts, like, I think you put it in here. Um, it was just my distortions, not your opinion on my thoughts. I don’t know if I can find it in here—I found one of them, but I thought—well, I kept getting this idea that if I were to kill myself it might bring my sister and my dad closer, you know. Because, I mean, I know that’s distorted, but that’s how I got hooked on stuff about dying. And, I understand that feeling like I was hostile, I was this little kid…I don’t feel like I’m doing well answering your questions, this is how my life is, it’s fine with me.”

“Is it confusing in a way?” I asked, as Alan ended his last two statements with questions regarding his clarity.

“No, I’m just not thinking very well, I guess, all of a sudden. I know you’re trying to ask the same questions in a different format here and the immediate reaction I had was, um, personal, um, using specific examples. How I deal with things that happen, like my mom coming in, or my stepmother coming in and my mom leaving. There were relationships with the girl, not allowing myself to get too close,” Alan explained.
“I started asking about capturing strengths and weaknesses, you seemed to think the first focused on weaknesses but did describe you accurately. You said this one seemed to describe how you saw things, so I wondered how you saw this one in terms of strengths and weaknesses.”

“I saw that one [DSM diagnosis] as more just kind of general. It was just talking about me generally and me as a patient and how to get better. And this one wasn’t like that, it was personal, it was—what was I gonna say—I just kept seeing I kept thinking about examples and I didn’t see it that way at all, either way. I mean, you know, I guess the more you say if my parents would have done this. Or, because I didn’t have a good relationship with my parents—which I understand completely—if I can’t relate to my parents how am I supposed to relate to other people. Yeah, it’s obvious that that one was more kind of general, but it pointed out strengths and weaknesses. This one was more personal, and it didn’t really get into that.” Alan and I were struggling. He was having difficulty discussing the experiential constructivist diagnosis, and I was finding it difficult to understand his struggles. He seemed to be saying that he struggled with the experiential constructivist diagnosis because of its personal nature. Alan also seemed to sense that discussing his relationship with his parents was distressing. I also wondered if Alan had difficulty telling me he did not like this diagnosis.

“Is that a good thing or a bad thing?” I asked.

“I liked it fine just the way it is. I mean you know, you know, a therapist I had, a lot of times, he wanted to point out positive things and experiences and everything like that, but in reality you have your weaknesses too and they need to be pointed out like, that you couldn’t pretend they don’t exist.”

“And you feel that one [DSM diagnosis] more pointed out your weaknesses or tried to help you work on them?”

“I think it shows me. It doesn’t point it out—I just think that, uh, using my examples, um—” Alan paused, and it seemed like he had some difficulty collecting his thoughts.

“Is there something about it, I guess I am wondering what makes it harder to talk about? It seems like since it’s more personal it’s a little harder to talk about.”

“Yeah, I guess it does in a way. To go from your other example [the DSM diagnosis], and it’s laid out in a kind of, I know it’s not written like this—I mean it’s written in paragraphs also, but it’s kind of broken down. And, yeah dealing with this one [experiential constructivist diagnosis], I think is more difficult. And, it makes sense, I mean I understand it, it’s just more
difficult to like pull from right away. It seems like the other one, it’s more like a flashcard, like pull it out or something. Something you can kind of just see it, and it’s done or whatever. This one, I like it, it’s just the use of all examples, which makes it personal. I guess it’s kind of hard to think of it that way. I think for patients it might be more helpful to see it that [experiential constructivist] way.” In Alan’s description of the DSM diagnosis as akin to a flashcard, he seemed to communicate that the DSM diagnosis was something easily digestible and did not need to be given much thought to make sense of it. It was something as easy to understand as a flashcard, a piece of paper that only needs to be glanced at to remind us of its meaning. The experiential constructivist diagnosis, however, was something that Alan had some difficulty with, even though he thought most patients would prefer the experiential constructivist diagnosis. I wondered if Alan felt threatened by the experiential constructivist diagnosis, especially by its inclusion of his past.

“How does this one help you see yourself in the future?”

“In the future? Um, I think mostly it kind of keeps me there. It doesn’t really see how I can work on my stuff to get better. It’s just kind of using my experiences to kind of push me back in the past I guess.” While Alan did not seem to value the personal and historical nature of the experiential constructivist diagnosis, he spent a lot of time concerned with his past and he often connected his struggles in the present to his relationship with his father. I thought Alan struggled to discuss his past because it was too threatening to conceive of himself in relation to past relational injuries. As Alan felt helpless in the past, he construed anything that reminded him of his past as having no hope for the future.

“So, in some ways, it keeps you in the past?”

“Yeah. Because of the personal examples, that’s why. But, I guess with patients—others might benefit with that more than me, I don’t know,” Alan responded.

I decided to push Alan a bit and ask him what he thought about various parts of the diagnosis that other participants described as helpful in understanding how to change. “What do you make about integrating the different parts of yourself, does that at all help out?”

“I remember when I read it I was like, it seemed like you were pulling—it seemed like there were two sides of something. Like this part [reads from diagnosis] may have felt as though you deserved more part from your parents, they acted in a way—okay, here, it seems as though you felt good about yourself, but felt there was something wrong with your environment, other
times it seemed like you were the cause of the events in your environment. Is that what you’re talking about?”

“Yeah, I guess what I’m asking is, does that help you see yourself in the future.”

“Well, I mean I guess it’s the same as in this one [DSM], I guess,” Alan responded.

“It’s like you said, you can’t change the past. Does this one help you think about those events differently?” I asked, hoping Alan would feel safer discussing the past.

“Okay, yeah, it’s exactly what you said. Integrating these two perspectives may make you feel more stable, you would be able to understand yourself and others. I guess I could understand that a couple of my views might be contradicting a lot of times—maybe. And, if I, kind of like I said, melded those together, I could be more consistent and I do understand, I must have overlooked it. I read it, but I’m not catching it all, but that’s what you were talking about just a minute ago. I feel funny ‘cause I contradict myself a lot and I don’t even know. When I tell my stories and the way I feel about it, I don’t know if I look at it a different way and create a different kind of view than the way I think about it now, I don’t know if, I’ve noticed before, that I contradict myself, but I don’t even know. I’ve tried to be kind of simple and kind of truthful, and tell the truth and present it in an easy way, but I definitely get flustered sometimes even though I really try not to. I don’t even know why this is that difficult, I told you all that stuff, and I guess just looking at it sometimes is difficult,” Alan explained. Alan seemed to take my comment regarding the different parts of him in a literal manner by lamenting the way he often contradicted himself. In contrast, I thought that his contradictions were the outward manifestation of confusion regarding his sense of self in relation to others. I believed that Alan found himself unable “to catch it all” because it was threatening. Alan seemed to be traumatized by the act of reading the diagnosis, making it difficult “to catch it all” even though he read the words and understood the concepts. However, he was able to introspect and talk about his contradictions.

“We’ve talked about feeling invisible, maybe something about being on paper makes you feel very visible?” I asked, hoping to move away from a literal interpretation of the diagnosis.

“I mean, I sometimes, I guess I felt abandoned at one time from my mom, and, even though I lived with my dad, I felt abandoned there. And, I felt like, if I was there, I was at the very bottom. You know like I felt like I overachieved in an area, I felt selfish, and you know they weren’t there at all for me. And, it was just my dad and my mom and my sister. I seemed
to be more gone. It seemed the dynamic changed. It started getting bad there and the more I thought about it.”

“It’s difficult to feel this visible.”

“It makes me feel visible? Not invisible?”

“Yeah, when you see it on paper. It seems a little harder for you to talk about this one, and I’m trying to figure out why that might be. I wonder if it’s putting it all on paper, making you feel very visible.”

“Yeah, it might be that. I mean I never sat down and wrote it out. Well, actually, one of my classes, one of those criteria is an autobiography. But, I guess it is hard for me to think that maybe my dad was this way and my step-mom really did affect me that much. And, you know, I think they could have done more to, there’s a lot more. It’s hard to see that, I mean I know I said it lots of times, but you know we went camping and met some lady and, all of sudden, she was a part of our lives.”

“So, for you it is like, maybe they should have done something, but then I feel selfish for thinking that. But, you are saying you wanted those things,” I offered.

“Cause I feel like my dad should have wanted to do more with me, and that to me is selfish, I guess. I mean that’s not how it should be, but I mean it really is. The fact that I think like this bothers me, because it’s not selfish, so it is two perspectives I guess. Like my suicide attempts, to me, that’s the most selfish thing a person can do. Yet, I’m trying to bring some of my family back together. And, I guess I understand how that’s confusing and it’s kind of two different perspectives and I don’t understand it now. I think, I mean I know what you’re saying now, but I don’t know why I do that.”

“It’s not really about blaming people, but understanding how these two perspectives come about.”

“It’s just because you pointed it out, and I never understood the two perspectives that way,” Alan replied.

“Yeah, no I’m saying, I’m talking about blaming people. I think I was asking about understanding how these perspectives came about,” I said, hoping that Alan would feel safer discussing the diagnosis.

“Looking back at it I try to think about what I did at that point in the moment. In the moment I was thinking two completely different thoughts about it.”
“Not blaming anyone, but figuring out responsibility—not blaming others too much, but also not blaming yourself too much. Sometimes, it feels like you blame yourself too much and other times when you feel something about your family member, whether that be anger or sadness, you also feel guilty.”

At this point, I lost some of Alan’s response as I switched tapes. Alan had increasing difficulty discussing his reactions to this diagnosis and I had asked him more directly about his concerns. He responded, “I feel bad, ‘cause I feel like this one you put so much more work into, you listed examples and came to a conclusion. I think that it, I mean it does sound like me and everything, you know the other one was just kind of simple-kind of approach, and this one is more kind of elaborated. Not ‘cause I don’t understand it, it’s just that the other is not nearly as specific.”

“You seem like you’re worried because you feel I put a lot of work into writing this one—” I said before Alan interrupted me.

“Not that you didn’t put work into the other one, it’s just that—”

“It seems you’re having trouble—”

“I’m assuming that this is the way your approach to therapy goes, kind of one direction. But I just—I feel bad because this one seemed like a lot of work, but it’s just not connecting with me. You know it is my personal story and I should be very connected with it, it just seems like the other one I’d go with, I think. It just seems more simple.”

“For me, I won’t be offended one way or the other, it’s not really a personal thing, I’m more curious to see which one, how people deal with different diagnoses. I’d rather you were honest with me.”

“Well, I read this and I understand this, it just for some reason it’s hard to explain when you ask me these questions. I think okay about just responding normally, it just seems more difficult.”

“Are you worried about what I think about, are you worried about what my opinions are?” I asked.

“Yeah, I was worried when I came in here. I knew it was a study and there are two diagnoses, two different ways of approaching it, and I worried that, that if I said this one wasn’t as good for me, it would upset you. I mean it’s effective, just not as effective for me.”
With hopes of making Alan feel safer, I discussed the importance of dialogue and multiple perspectives. He remained unsure because he was aware that different therapists had different ways of approaching clients. I explained that while it was important for us to have a conversation regarding my perspective and rationale behind the study, it was more important for me to hear his perspective. I said, “It seems as though you fear offending me.”

Yeah, ‘cause I think it’s really good, I feel like it describes me a lot. I just feel like I’m not answering the question right or something. I don’t know if I’m losing my concentration or something or what, I’m just having a heck of a time.” My earlier hypothesis regarding Alan being threatened by the experiential constructivist diagnosis seemed to be valid.

After I stressed the importance of seeing how those diagnosed responded to these diagnoses, Alan said that he thought about such matters quite often and he hoped he could be of help. I explained that some people had different preferences regarding the diagnoses and how it was important to understand why people choose one over the other. Alan seemed to agree when he said, “I mean a lot of times therapists pull out that book and show you your symptoms and that’s it.”

“I would rather hear your honest thoughts—I’d appreciate it either way,” I responded.

“That’s good, that you take it and just go over and over it again and start really thinking about the people. Like I said, they take you in the office and they just kind of diagnose it right there. I’m not saying anything against the therapist, it’s just an example. I just feel bad—I like the form—it’s just hard for me to explain why.”

“Which one you like isn’t going to change my opinion of you at all. I really enjoyed talking with you last Friday and I am enjoying our conversation today, so it’s not going to make me think less of you,” I said. While Alan was not completely satisfied, he felt more comfortable than he had earlier and was prepared to continue with my questions.

“So, how does this one make you feel about changing, personal change, growth?”

“I don’t know if it tells me how I can change, it just uses an example and kind of explains why that may have affected me. Um, you know, the things that I do want are just what people want normally. I mean that’s not too much to ask for. I mean more attention and love and you know, um, I mean it’s just, it shows me that my problems aren’t you know any less important than my feelings are. That they’re okay to have. I don’t do it the right way a lot of times. I mean I guess I can say, I need to be content with myself and, maybe I shouldn’t think so much
about what I do. I always think about the little stuff, and kind of let it be what it is,” Alan explained. Alan understood the experiential constructivist diagnosis as a way to explain his past without offering much in the way of changing or growth. *The ways to feel more stable and consistent, were, for Alan more of an explanation of the past rather than the beginning of a path for the future.*

“How about this one? Do you feel comfortable with this one being disclosed to others?”

“I still like it, even though it’s personal, just using specific examples. You know I’d still be okay with it. I could understand why maybe some people wouldn’t be though,” Alan explained. *While Alan did not feel comfortable with the personal examples, he did not seem to be bothered by others reading the diagnosis.*

“Okay, I would like to do the same exercise as before. I’m going to have you imagine that you’ve never met a therapist face-to-face and you’re using this to understand your therapist. What would be your initial thoughts about this therapist be?”

“You know, compared to the other one, you take the specific examples and put it in a way that would help. I mean, I’m sure that I don’t see it very well. You see it in a way that we could work on, which is fine with me. I just don’t explain it that well.”

“How would hearing this at the beginning of therapy, make you perceive the therapist?”

“I don’t know at times it might bother me and at times, okay, how do I see it? You know it might be…because that’s what I’ve been doing, but that doesn’t have anything to do with the therapist. I mean as long as they approach it in a decent way I mean I would be fine with it. I might feel kind of bad, but I’m going to either way.” Alan seemed to say that as long as he was treated well or decently, the understanding used by the therapist would be less important.

“How well do you think this therapist would understand you?”

“Um, you know, fine. Again, they’re using specific examples, so I think that this is a fine one to approach in therapy. I think that they would understand me. Like I said earlier, at times, I think sometimes it might be difficult to understand, but I think they do a good job of explaining it, it just might take me a couple times to run through. But, they know what they’re doing and I think they’re trying to help me out,” Alan explained. *While a therapist using the experiential constructivist diagnosis would understand Alan, Alan might have difficulty understanding the therapist.*

“Does this therapist trust your experience of your feelings?”
“Yeah. I’m not sure why, but I think they would,” Alan quickly responded.

“How do you think this therapist sees your ability to change?” I asked.

“I know I need to. I think they may be more willing to take longer to go through I guess, I’m not really sure. I think this person would be willing to spend more time working on these things.” Alan suggested that working on his struggles in this way may require more time.

“Do you think this therapist would be effective for you?”

“Yeah, like I said I would have to read it a couple of times, read it more carefully and try to see what they’re saying and what they want to do. I think that one [DSM diagnosis] is easier than this one, but this might be better, ‘cause it just might take a little more.

“Would you trust this therapist?” I asked, continuing with my questions

“Yeah, I would feel comfortable,” Alan replied without elaborating his response any further.

“Do you think the therapist is limited in anyway?” I asked.

“No, once I got past understanding it completely. Yeah. Even though this is the same story as the other one, I think that this approach is a good one and I would feel kind of nervous the first time, you know?”

“Now I would like to compare the two a little bit, um, we talked a little bit about, it seems that you prefer the first one.”

“Right.

“Say a little more about what makes that your preference,” I asked.

“I don’t know if maybe it makes me feel easier or not. Like I said, it’s just about personal—just so individual, and, for me, it makes me think about all the things that I’ve done, even though I do that, I don’t like to think about these things. So, to put it this way and I just see it just kind of the more general approach, it’s just easier for me to get into it and I don’t really know why and this way I get kind of depressed just reading it. It’s just kind of rehashing all of those problems and stuff like that.” Because Alan ruminated on his past, the experiential constructivist diagnosis reminded him of aspects of his past that may have not been in his current awareness.

“Would you add anything to one or the other to make them better?”

214
While much of his answer was inaudible, Alan seemed to reiterate the ways the DSM diagnosis was akin to a snapshot or flashcard and the experiential constructivist diagnosis was a richer description, even if it was confusing.

Alan continued, “Like I said maybe I was reading it and I was just kind of getting lost, every now and then I lose my concentration because every time I look at it I’m seeing something different. I don’t know I do like—it would probably take me a few times to read it, but I do like the way it is. And, I think you have the insight of what I’m going through and what I’m thinking. You know, in some ways, this is the most difficult to deal with, but it might be more helpful for me. This one [DSM] is kind of general maybe harder to relate,” Alan said. Because he seemed to change his mind about the experiential constructivist diagnosis, I was concerned that Alan was trying to please me.

“How does one give you more hope than the other one?”

“Initially this one did [DSM diagnosis]. Because it was general and things like that, and this one was kind of depressing by the way it’s put, but, I think the more I read this the more I agree with it—the more I would see how the second one is helpful,” Alan explained.

“I guess I find myself wondering if you feel like it is more helpful more now. Or, are you trying to answer in ways that you think would make me happier?”

Alan laughed and said, “I think mostly, it’s the more I look at it—I’m not even seeing, I mean, I might even seem like I have a real short-term memory a lot of times when I’m seeing something and asking to see something in a different way.”

“Do either one of them make you feel like a victim?”

“Yeah. Probably this one [EPCP]. Because it has specific examples and things like that that probably make me feel more a victim.”

“Using our imaginary therapists, would your thoughts about the therapist change depending on which ones they used?” I asked.

“Well, they each have their own way. I think no matter how they put it, I’m fine with trying to look at it through their perspective. If they’re trying to help me then that’s fine.”

Alan’s belief that he had to look at himself through his therapist’s perspective may show the power therapists have when diagnosing clients. It also may help to explain Alan’s difficulty having his own perspective of the diagnosis.

“So, it’s more if they are willing to help you and not really the one they are using.”
“Yeah, ‘cause I always think, they have a good grasp on how things are going.”

“Do you see one being more effective? I mean we kind of talked about it already, but do you see one being more effective than the other?”

“I think A [DSM diagnosis] for me is better for my kind of thought process or thinking—more effective. I just think some people work better with seeing it like it’s kind of a like a general description-type thing rather than real in-depth right away,” Alan said.

“Would you feel more comfortable with one therapist or the other?”

“I don’t think so. I mean whatever this one’s [experiential constructivist] thinking about, my examples then trying to use it to help me. And, ‘A’ [DSM] I think I understand everything just fine. And, they would still know my personal story. I mean, yeah, I don’t really have a problem with either one of them.”

“Do you have any more thoughts before with finish?” I asked.

“I really like the way, still even reading it, it [experiential constructivist diagnosis] just right away jumped at me, even though this isn’t my personal choice it just kind of jumped out at me more. Does that, do you know why? Is it just like my thought process?” Alan asked.

Interestingly, the experiential constructivist diagnosis, which Alan did not prefer, stood out to him more.

In response to Alan’s question, I reiterated some of my earlier thoughts regarding Alan’s difficulty dealing with his past and, because the experiential constructivist diagnosis represented Alan’s past, it was more difficult for him to construe. Alan replied, “Yeah, the more I read the last few pages, the more I think about it, it just had so much about my personal experience…and that’s why I was starting to lean more towards that one [DSM diagnosis], you know, initially. But, after reading that, just kind of skimming it throughout our conversation, it just seemed like I didn’t see things the first time I read through it… maybe that’s why I lost concentration and skimmed through those last pages. You know, as I think about it a little bit more, and I may go with ‘B’ also.”

Alan seemed to validate my observations in his response. While it is difficult to tell which diagnosis Alan preferred, it seems clear that Alan felt threatened by the EPCP to the point where he had difficulty reading the diagnosis thoroughly.

Discussion

I found that all of participants’ provided evidence for the utility of the experiential constructivist diagnostic system in a variety of ways. While expressed in different ways, each of
the participants described the experiential constructivist diagnosis as an understanding that allowed them to access deeper emotional struggles. Similarly, participants also affirmed that change or healing from the point of view of experiential constructivism would be difficult yet meaningful and rewarding. While Alan did not say this as strongly as other participants, he thought the EPCP diagnosis could yield change, even if it was too threatening for him. However, the participants’ responses often were mediated by a tension between feeling more human versus feeling threatened in response to the EPCP diagnostic system. While experiential constructivism holds that feeling threatened is inevitable in being fully human, persons injured early and profoundly may have difficulty negotiating threat. Participants felt the experiential constructivist diagnosis respected their humanity or was threatening to them (or some combination of both). As the purpose of experiential constructivist diagnosis and therapy is to engage clients around the struggle (Leitner, 1988, 1999) of choosing richness yet potential terror versus safety yet emptiness and isolation, the notion that the experiential constructivist diagnoses either threatened or affirmed participants’ humanity indicated that the diagnosis was successful in engaging clients around the struggle to risk safety for richness. However, the diagnosis was less useful to participants who felt more threatened (David and Alan).

For instance, Simon described how the diagnosis did not treat him as an animal but rather a human being with great strengths and faults. He said,

I feel like I'm an individual and the things that make me who I am are not medical definitions—and this one [DSM diagnosis] is kind of like white suit coat, kinda lookin’ in the fish bowl, lookin’ in the lion’s cage while the lion is in the cage. Saying, “Oh, he’s from the genus yadda, yadda, yadda, he consumes fifteen pounds of meat a day, by the time he’s five years old he will have grown to his full.” This one [EPCP diagnosis] is kind of like more hands on, you’re kind of like in the cage of the beast. The lion is getting to know you a little bit and you’re getting to know the mannerisms of the lion, you know. This [DSM diagnosis] is kind of like, stand back, “It is a typical black male, came from a broken family,” kind of a little further off, a little stand offish you know.

Simon also validated that change from the perspective of experiential constructivism would be difficult yet more meaningful, as he felt he would need to learn how to negotiate trust with others, something he could not do with meaningful others in his life. David, on the other hand, found the experiential constructivist diagnosis threatening yet also believed he could not
meaningfully heal without the diagnosis, exemplified in his discussion of preference. While he preferred the DSM diagnosis, he believed that the EPCP diagnosis was both more effective and more accurate. He explained this complexity by citing the Pink Floyd song “Comfortably Numb.” If he were to change according to the DSM diagnosis, he could stay comfortably numb. Conversely, the EPCP diagnosis would be more difficult as it would require him to revise and elaborate his most core constructs. Thus, the EPCP diagnosis felt threatening to David.

I will discuss the results of the study in terms of the tension between feeling threatened versus feeling respected. First, I will discuss the themes in terms of their implications for the experiential constructivist diagnostic system. I then will suggest revisions to the experiential constructivist diagnostic system. Throughout, I will suggest avenues for future research and discuss limitations of the present study. Lastly, I will discuss the role experiential constructivist diagnosis could play in promoting viable alternatives to traditional, psychiatric diagnoses.

**Themes and Implications for EPCP diagnosis**

*Expansiveness/Constriction.* Leitner and Guthrie (1993) described that the impact of therapist’s interventions can be assessed along a continuum of client responses. One way that clients validate therapists’ interventions is bringing in new information or describing their experience in novel ways. In this context, each of the participants validated the EPCP diagnosis, as participants’ responses were richer in that they provided more information and began to revise their understanding of self and other in relation to the EPCP diagnosis. By way of contrast, participants’ responses to DSM diagnoses often were in the form of affirmative or negative, one-word responses. For example, Janet basically reiterated our first interview when presented with the DSM diagnosis. She described recent incidents that left her feeling mistreated and invalidated. On the other hand, when presented with the experiential constructivist diagnosis, I decided to abandon my role as researcher, as the diagnosis elicited an outpouring of new information that was distressing to Janet. Even in the case of Alan, who preferred the DSM diagnosis, the EPCP diagnosis elicited more information from him. For instance, Alan elaborated his relationship with his father further in response to the experiential constructivist diagnosis, even though he felt it was unnecessary for his treatment.

Because I had the opportunity to meet with Simon more than the other participants, I was able to see how he continued to process the diagnosis. Simon continued to bring in more information and describe his experience differently. For instance, I was concerned that Simon’s
expectations would not be met in the conversations he hoped for with his parents. In our last meeting, Simon seemed more flexible in that he seemed able to tolerate the idea that his parents would not be able to answer his questions and was content with whatever they could give him. Simon was angry with his parents for not providing him with a sense of direction in the context of their different and conflicting worldviews. He then lamented that he had worked so hard to bring his parents’ perspectives together. Simon seemed to be aware that his upbringing imposed some limitations on him but that he had made choices in how he constructed his life. Thus, Simon forgave his parents less easily, signifying that he was willing to feel the pain of past experience, and had a heightened sense of responsibility for his choices.

Future research could investigate systematically what parts of the diagnosis elicit more information from clients. Future research also could investigate how people process the diagnosis over time. Having the opportunity to meet with Simon over a longer period of time provided me with useful information regarding his use of the diagnosis. A project focusing on tracing participants’ use of the diagnosis would yield valuable information concerning experiential constructivist diagnosis. In this project, researchers could use a similar procedure as I did, but they could continue to revise the diagnosis after each meeting in order to trace participants’ use of the diagnosis. This project could help experiential constructivists understand how clients construe the diagnosis over time. Furthermore, such a project could also help explain how clients feel threatened by the diagnosis. For instance, by assessing change on diagnostic dimensions (e.g., responsibility), researchers could observe how these ratings change over time in comparison with the client’s feeling of threat.

**Strengths and Weaknesses.** All four participants said that the DSM diagnosis focused on deficits or weaknesses. When discussing the DSM diagnosis, Alan explains this focus on deficits:

I think it’s a good interpretation and everything. I mean it’s right now, it kind of sucks, but that’s the way I am, so…I was just disappointed in myself because that’s the way I am…Not disliking what you put down, it’s just the fact that I am that way…I mean I think, I could have been a lot more. I had a lot of potential. I kind of fell through. I guess a lot of it is that, I had such low self-esteem that I allowed myself to fall through. So, I think, it’s my fault. I just think I could have done a lot of things that could have changed that. I feared a lot of things and I was scared.
When discussing the EPCP diagnosis, Alan thought the diagnosis went beyond strengths and weaknesses and, instead, described his idiosyncratic perspective on the world. I think, you showed the things that are meaningful to me and what is important to me. Kind of like—I think what I’m trying to say is like, you said what I said, what I kind of want to do, what’s important to me, like my culture and knowing about my mother and me and my dad and the cultural heritage and things like that. Well, I think mostly it’s just a description…like you know I really think that there weren’t any positives and negatives…you describe, like how I looked at things. And, I didn’t see that really as a strength or weakness, but more like who I am. And, I don’t know if I’m making any sense, I don’t know. I found it appropriate. I mean I don’t really see. I just see like you explaining…you know what I mean?

Participants felt that the EPCP diagnosis captured the way they struggled to feel solid and permanent and represented their strengths along with their weaknesses. Not surprisingly, then, some participants felt safer and were able to access the parts of themselves that they felt were strengths. The client’s responses are important for EPCP theory because they provide evidence for the need to feel solid and stable despite experiences that make it difficult to do so.

The EPCP diagnosis, by describing people in ways that transcend strengths and weaknesses, neither pathologized nor ignored participants’ pain by moving to descriptions of how they saw the world. Through its description of how another construes the world, the EPCP diagnosis may help therapists connect more deeply with their clients. Future research could investigate how each diagnosis helps therapists connect to their clients. For instance, therapists could describe how different diagnostic conceptualizations affect their thoughts about their clients. As the DSM offers few, if any, discussions of strengths, researchers could see how therapists’ conceptualizations of clients change depending on the type of diagnostic system.

*Treatment Implications/Growth.* Most participants believed that the EPCP diagnoses had treatment implications built into the diagnosis itself. For instance, Janet said,

Well, I guess in some ways it’s almost like it gives both sides of things and, at the end, it’s kind of a solution to it…Like I'm just looking at the first page, where you say, “At these times it seems that you also see others as accepting and caring, which allows you to be more flexible with them and at other times it seems as though you understand yourself as angry and are less accepting of your emotions and actions.” That gets like both sides
and, then, you end in saying that, “at these times you may fear others as they seem most
dangerous and hurtful. Integrating these two sides of your self may be a struggle that
may allow you to feel more solid and stable.” That kinda gives both sides again, and a
solution. Kind of bringing it together.

Describing how Janet could feel more solid and stable, by overcoming a fragmented sense of self
in relation to others, gave her concrete ways she could change.

David’s reference to pop culture, namely Pink Floyd’s “Comfortably Numb,” is a striking
example of the power of the EPCP diagnosis. For David, changing according to the DSM
diagnosis would allow him to stay comfortably numb, while the EPCP diagnosis would
challenge him to consider his past and revise his most central constructs. Thus, while David felt
that both diagnoses would help him change, the nature of these changes would differ
dramatically. While the DSM diagnosis would bring about change in that David’s symptoms
would decrease or his behaviors would be more palatable to others, the EPCP diagnosis would
require that he confront the pain of the relational injuries he experienced at an early age. He also
would need to process the guilt regarding his actions towards others (e.g., his sister’s pregnancy,
his violence towards women). Because he viewed the DSM diagnosis as not making him face
painful experiences, he believed that change from the point of view of experiential
constructivism would be more difficult yet more meaningful. Each of the participants validated
the notion that the experiential constructivist diagnostic system allowed them to access deeper
emotional struggles. Future research could examine how accessing deeper emotional struggles
affects treatment and future growth.

*Threat.* The EPCP diagnosis emphasizes the idiosyncratic constructions of experience,
especially how constructions of self and other arise. It also implies that all pieces of one’s
experience are significant and that one is able to choose how one constructs the world. Two of
the participants found the EPCP diagnosis threatening because of its implications and its
inclusion of the past. For instance, David felt the EPCP diagnosis required him to examine and
take responsibility for his past behaviors, especially towards women. While he knew it was
impossible, David would like to forget about his past. He also had difficulty examining how his
constructions of sexuality and gender came about. Alan struggled to hold the tension that he is
not only limited by his experience but also has agency to choose how he constructs his
experience. Because the EPCP diagnosis focused on such tensions, Alan had difficulty
comprehending it. David explained that it would be difficult for him to understand how the imaginary experiential constructivist therapist organized his experience. He said, “I can’t, I can’t focus—not focus—I can’t comprehend. I’m trying to comprehend, but it does make sense. I do understand it and I can’t comprehend at the same time.”

Like David, Alan could not construe the diagnosis even though he understood the words. Alan felt the EPCP diagnosis stood out to him more even though he preferred the DSM diagnosis. For instance, I noticed Alan had trouble with the EPCP diagnosis and said as much. He responded, “No, I just I’m just not thinking very well, I guess, all of a sudden. I know you’re trying to ask the same questions in a different format here and the immediate reaction I had was, um, personal, um, using specific examples.” Later in the interview, I asked Alan if he thought integrating the different parts of his experience was useful. He seemed as though he did not know what I meant, searched through the diagnosis and said,

Okay, yeah, it’s exactly what you said. Integrating these two perspectives may make you feel more stable, you would be able to understand yourself and others. I guess I could understand that a couple of my views might be contradicting a lot of times—maybe. And, if I, kind of like I said, melded those together, I could be more consistent and I do understand, I must have overlooked it. I read it, but I’m not catching it all, but that’s what you were talking about just a minute ago. I feel funny ‘cause I contradict myself a lot and I don’t even know. When I tell my stories and the way I feel about it, I don’t know if I look at it a different way and create a different kind of view than the way I think about it now, I don’t know if, I’ve noticed before, that I contradict myself, but I don’t even know. I’ve tried to be kind of simple and kind of truthful, and tell the truth and present it in an easy way, but I definitely get flustered sometimes even though I really try not to. I don’t even know why this is that difficult, I told you all that stuff, and I guess just looking at it sometimes is difficult.

Because Alan felt traumatized when he discussed the past, the ECPC diagnosis was threatening to him. Interestingly, both of these participants felt the EPCP diagnosis was accurate and useful, even if it was not their preference.

The participants’ most core constructs seemed to be touched by the diagnosis. Clients often felt very exposed, something that was difficult for some of the participants. Because they had been injured so profoundly and early, trusting others with their experience was difficult. If
intimacy can be threatening, especially with profoundly injured persons, then threat could signify the diagnostic system made clients feel closer to those trying to understand their experience. Further research is necessary to ascertain why some clients have stronger feeling of threat than others. In the next section, I hope to explain how some clients may come to feel less threatened.

Relational Trust. The EPCP diagnosis often elicited themes of trust from the participants. For instance, David described how it was difficult to trust others in relation to the experiential constructivist diagnosis. Simon described needing to be able to trust his therapist if treatment from the experiential constructivist diagnosis was to be effective. Trusting others involved moving beyond an individualist perspective to a more communal perspective. David articulates this well:

It [EPCP diagnosis] helps me. It’s helps me change…It makes me think, ‘Don’t think about negative thoughts.’ No, I mean they happen to you, yes, and it could happen to anyone. And, you, you’re not the only one. I mean it’s not about just me me me me me. There’s other people that have been in my situation and there’s people that have been in the exact same situation probably, there has to have been, I’m not the only one in this world.

People who struggle with self-other permanence may have a relatively isolated and solipsistic view of the world. David’s statement that others struggle similarly seems to allow him to take the perspective of others. EPCP’s conception of reverence is important here. If persons move in the direction of having reverence for others, the diagnostic system serves its purpose of helping persons negotiate the vicissitudes of trust and intimate relating. In this regard, Simon said,

This one [points to DSM diagnosis], I can touch it and say, “That’s wrong. That’s not me. It says normal functioning.” It’s flawed, you know what I'm sayin’, I can maybe recycle this [DSM diagnosis], you know what I'm sayin', but the less tangible one [EPCP diagnosis] I have to rely on something bigger than me to guide me to understand it. I can’t touch that one. This one I can touch and I can say—I mean, if you believe there’s an ultimate good in the universe and there’s an ultimately bad, I can say this [points to DSM] is ultimately bad. And, this [points to EPCP], coming into contact with this, validates my leaving this path, ‘cause this is [DSM diagnosis] ultimately evil because it purports to try to understand things in a way this is deceasing, it’s dying, it’s fallen by the
side. So, this [DSM diagnosis] is kinda like Lucifer, and that one [EPCP diagnosis] makes me believe in something bigger than myself, ‘cause that’s [EPCP] more me than this [DSM], that’s [EPCP] more of my flesh. This [DSM] is not my flesh. This [DSM] is something that is not going to be here eventually. I’m pushing this back underground and I’m trying to fertilize the earth with that.

The EPCP diagnosis felt vital for Simon (i.e., “that’s more of my flesh”), but also was intangible and difficult to grasp. The experience of self and other often is intangible, and persons may need to believe in something larger or outside of themselves to trust, risk and meaningfully relate to others. As Simon said, one needs to believe in something larger than oneself and believe in others in contrast to understanding oneself in ways that feel dead. Future research would be helpful in examining whether and how persons who do not believe in something larger than oneself feel so threatened that they are petrified of the EPCP diagnosis. Future research also could examine the ways that helping people see a bigger picture allows them to reduce threat and move forward with the experiential constructivist diagnosis. Future research also could explore if persons are threatened by the DSM diagnosis in relation to the EPCP diagnosis.

*Shift of agency.* When asked to imagine a therapist using the EPCP diagnosis, participants located the responsibility for healing in themselves or the relationship between client and therapist. When asked to do the same exercise with the DSM diagnosis, participants often shifted agency to the therapist, making him or her the catalyst for change. For example, in response to my question regarding how he understood change in relation to the EPCP diagnosis, Simon said:

> I think we could go into training like an athlete you know what I'm sayin’. We can do wind sprints together, we can do calisthenics, but you can’t run the race for me…You can just kind of coach me to get to that starting point and prepare me up to that point, but I have to say “Mom, dad.” I have to take off…when the gun go[es] off.

By way of contrast, Simon’s response to the DSM diagnosis was quite different: “I think that would have to come from the clinician.” Later, when comparing the two diagnoses, he continued discussing agency and responsibility:

> I feel like, number one [EPCP diagnosis], it’s my responsibility and, number two [DSM] is a source of betterment for me, you know, it’s an occupation. I guess I want to have more experiences that are akin to the first one, more so than the second one.
The EPCP diagnostic system is built on the assumption that change or healing takes place in relationship (Leitner, 1985, 1988). When agency and responsibility is placed within the therapist, the person’s innate process of healing may be hindered (Bohart & Tallman, 1999). The participants’ locating agency within themselves or the therapeutic relationship provides evidence for the belief that clients’ innate process of healing is fostered by the EPCP diagnosis. Future research could investigate how different theories of psychological healing affect how clients construe agency and responsibility for change. For instance, therapies focused on symptom reduction often place responsibility in the realm of the therapist, while relational and client-centered therapies place healing within the relationship or the client, respectively. Future researchers could address how these theories affect growth and recovery.

*Death/Affirming Vitality.* Two participants described the DSM as akin to death. As the DSM conceptualizes thought disorders as degenerative illnesses, participants felt there was little hope for them. David’s response to my question regarding how he saw himself in the future in relation to the DSM diagnosis exemplifies lack of hope:

> Stuck in a state hospital probably—for the rest of my life. A group home or nursing home, that’s what it seems. Of death…I’d think there’s no hope for me, especially after those last few lines [of he DSM diagnosis regarding prognosis]. I’d think, “Oh, I’ll go kill myself and all.” It’s a lot to take.

Simon expressed a similar sentiment. In response to the DSM diagnosis, he said:

> I mean I like it [DSM diagnosis] because it kinda represents the old order…something that’s dying away—like a dinosaur…It’s real, ahh, rigid. It’s not as abstract, you know what I'm sayin', I feel for one to be, maybe successful, in this universe, one would have to be flexible and contort and shift weight, and to bend and move…this first one [EPCP diagnosis] is more flexible, the second [DSM] is more rigid. If I embrace this [DSM], I feel like eventually I’m going to be destroyed because it’s going to keep me from being able to move, it’s going to be my death ultimately. This says the white male perspective of history for the past, at least 2000 years, has been Anglo-Saxon, European, I don’t know, right wing. These are ideas of morality. These are ideas of normality. You don’t fit into this category, normal, and my god that led us to reasons to, that’s on our money, that’s on our license plates, it’s going to crush you…So, if I embrace this [DSM], it’s like I’m embracing death. There won’t really be comfort, when this idea [DSM] rules the
universe. This flexible one [EPCP] will be a cover for me, will be a jacket, will be a roof when this one [DSM] is in authority.

EPCP holds that intimate relationships (Leitner, 1985, 1988; Leitner & Faidley, 1995) bring vitality, richness and meaning to our lives. However, the DSM diagnosis elicited themes of death, the very opposite of vitality. Simon finds solace in the EPCP diagnosis, using it to protect himself from DSM diagnosis. As the EPCP diagnosis can inspire persons to engage the struggle between life and death, between emptiness and richness, the participants’ responses provide evidence that EPCP diagnosis activates the struggles needed in EPCP therapy. Thus, the diagnosis is consistent with the therapy and EPCP theory. Future research could investigate whether hope influences treatment prognosis. Future research also could systematically investigate whether meaningful recovery involves richness, meaning and vitality.

Future Research and Revision to the Experiential Constructivist Diagnostic System

While researchers have elaborated experiential constructivist theory over the last twenty years, the EPCP diagnostic system is still in its infancy and researchers have not examined the diagnostic system in as much detail. From the results of the study, I see two possible avenues for future research. First, future researchers could focus on the diagnostic system by further elaborating and clarifying the constructs. Second, future researchers also need to understand the generalizability of the diagnostic system. For instance, at this point, experiential constructivists do not know if therapists from other orientations could use the system meaningfully. Because I am not only interested in exploring the diagnostic system, but also promoting an alternative to the DSM, I believe research focusing on the diagnostic system’s generalizability should not be ignored. I used this distinction, between research on the system and research to promote the diagnostic system, to organize my discussion of future research and revisions.

Future research could focus on the connections between the three axes of the diagnostic system. As the three axes are different ways of describing the same phenomena, they are inextricably connected. Future research could help experiential constructivist researchers understand the implications of these distinctions. For example, one could research how struggles with responsibility differ when one lacks self-other permanence compared with lacking self-other constancy. Experiential constructivist therapists have observed that persons struggling with permanence often struggle more significantly with the experiential components than one struggling with constancy. However, I did not observe such a connection from the interviews.
As Alan appeared to have some sense of self-other permanence, the diagnosis group conceptualized him as furthest along the developmental trajectory. However, Alan’s struggles with responsibility were the most significant of any participant. Such studies also could elucidate how the three axes describe the same phenomena differently. For instance, case studies could be written that describe a client’s struggles on axis I and axis III in order to provide examples of the connections between the axes.

From the present research study, it appears that the descriptions of self and other were the most important facet of the diagnoses for participants, as a majority of the themes I delineated previously involve participants’ struggles with structural arrests. Further research could help experiential constructivism understand the nature of self-other permanence versus self-other constancy in more detail. For instance, future research could clarify permanence struggles from constancy struggles (e.g., how to identify permanence and constancy). Additionally, researchers could examine if different clinicians familiar with experiential constructivism rate clients similarly in terms of permanence and constancy. Raters and researchers then could discuss and clarify discrepancies. It would be difficult to develop the diagnostic system, without a clear understanding of permanence and constancy. A similar study could be done that compares raters’ understandings of all the diagnostic constructs.

Future research also could address how structural arrests lead to struggles with self-other permanence and constancy. While experiential constructivist researchers and therapists have observed that early relational injuries often manifest as struggles with permanence, later traumas also could upset self-other permanence and constancy. Further research could help elucidate the ways severe traumas could impact the construction of self and other. For instance, traumas experienced later in life, if severe enough, have been observed to lead to struggles with permanence and constancy (e.g., combat, death of a parent or child, sexual assault). Thus, researchers could investigate how persons’ initial constructions of self and other are related to the ways they construe later traumas.

Lastly, researchers should replicate the present study with less severely injured persons. Because all four participants were injured profoundly and early in life, we do not know how less severely injured persons would compare the EPCP and DSM diagnostic systems. It also is unclear if the diagnostic system could adequately describe less severe struggles.
Future research could focus on how therapists use the diagnostic system. A similar project could be undertaken where therapists are given their clients’ EPCP and DSM diagnoses and asked to discuss the diagnoses as the participants in this study did. Such a study would explore how professionals with different theoretical orientations use the diagnostic system.

Future researchers also could explore different ways to construct and write diagnoses. For instance, I wrote the diagnoses starting from axis I and moving to axis III. However, moving in the opposite direction could be clearer, and, possibly, less threatening to some clients. Participants in my study may have felt threatened because core constructs were the first topic I introduced. As core constructs are persons’ most central and important constructs, some participants may have been unable to overcome initial threat and read the rest of the diagnosis. Thus, future researchers could investigate different ways of writing the diagnosis and the impact of these differences on clients.

Exploring alternative ways of structuring the diagnostic system in order to make it more useful to clinicians would be useful for experiential constructivist therapists. For instance, the three axis system may promote the idea that axes are distinct. If so, discarding the axes might make the system clearer to clinicians. Inventing and investigating other ways of representing the system is necessary, as it is difficult to remain theoretically rich and user friendly.

**Implications for Criticisms of DSM**

Critics of the DSM have argued that the DSM is based upon certain values to life and imposes a constricted view of healthy and normality on those diagnosed (Cushman, 1990, 2002; Farber, 1990, 1993; Hillman & Ventura, 1992; Laing, 1967; Leifer, 1990; Levine, 2001 Leifer; Szasz, 1960/2002). In pursuing the present project, I have contended that the experiential constructivist diagnostic system is a viable alternative that overcomes these criticisms. While all theories are built upon certain assumptions and values, it appears that participants felt the vision of human pain and distress provided by experiential constructivism allows for a rich understanding of their struggles and growth or recovery.

Even though some critics have called for the abolishment of the practice of diagnosis altogether (Szasz, 2002), constructivism holds that diagnosis is an inherent component of psychotherapy, as it provides a foundation for psychotherapy. While others have provided alternatives (see Beach & Kaslow, 2006; Beutler & Malik, 2002; Follette, 1996; Neimeyer & Raskin, 2000), they have not been well researched and may not overcome the criticisms I
discussed in the introduction. While it remains unclear if therapists of different theoretical orientations can use the experiential constructivist diagnostic system meaningfully, the results of the study imply that clients prefer this approach to the DSM, evidence for the utility and viability of the diagnostic system. While I cannot be sure that other critics of the DSM would agree with my assertion, I find the system to be more respectful of all aspects of person’s humanity and, thus, preferable to the DSM.

Instead of closing with my words, I would rather close with a quotation from Simon that summarizes the project in a more eloquent and powerful fashion than I could:

I don’t wanna pay into this idea, this medical, this clinical description of who I am, I…wanna move as far away from it as possible. I want my experience to be experienced by people after me with people that wanna touch, that wanna feel and see and embrace, rather than [say], “This is schizophrenia, the paranoid type.” That type. I don’t want clinical. I want “Man, he came past this sign and he had a bad day. He went back to his room and wept for a few hours.” Something, to make it easier for other people that, when they sit in this seat, they can touch the things and say, “Ahh, we are not blind…we do feel, we do experience.”
References


232


Informed Consent

Description of study. I am participating in a research study in the Miami University Psychology Department. The purpose of this study is to better understand clients’ perceptions of the manners in which psychologists and psychiatrists conceptualize their struggles. Mental health professionals use a variety of approaches to therapy. Because there are such a variety of approaches, there are also a variety of manners in which professionals conceptualize human struggles.

This study will focus on two approaches in particular. My participation in this study includes three phases, should I agree to participate. First, I will undergo a standardized assessment in order for the researcher to conceptualize my struggles from the first perspective. In the second phase, the researcher will listen to my initial therapy tapes to conceptualize my struggles from the second of these two perspectives. In the third phase, I will receive two descriptions that therapists might use to conceptualize people whose struggles are similar to mine. I will then discuss my perceptions of these two conceptualizations with the researcher. The researcher will ask for my thoughts, opinions and feelings about these two descriptions, as well as my understanding of psychological problems in general. I realize that these conceptualizations are theoretical constructions and may not accurately represent my strengths and weaknesses. I also understand that this interview will be recorded on audiocassette. The purpose of this study is to examine clients’ perceptions of different theoretical conceptualizations, not to arrive at a comprehensive and final description of me. In other words, I understand that neither of these descriptions may be accurate. I also understand that neither of these conceptualizations may be the basis of my therapist’s understandings of my struggles. However, the researcher will discuss these two understandings with my therapist. My total participation will require at most 90 minutes.

Risks. I may experience some discomfort at being asked to disclose personal information during my interview. I may choose not to answer any questions or discuss topics with which I am uncomfortable, and may discontinue my participation at any time. If I feel any discomfort surrounding the discussion of my struggles, I understand that my current therapist is available for consultation.
Benefits. My participation may help advance professionals’ understanding of diagnostic tools. I will also receive some information about different conceptualizations of my struggles, which has the potential to deepen my understanding of these struggles. I may also be better able to engage with my therapist around these issues.

Confidentiality. Only my interviewer will have access to identifying information about me (e.g., my name, where I live, etc.). A group of clinical psychology graduate students may be asked to listen to my initial therapy sessions to validate the researcher’s conceptualizations. Any verbal and written information I provide may be used in published research reports. I understand that someone who knows me well may be able to recognize some of my statements. I have the right to specify which personal information I would like to have falsified (i.e., changed) to protect my anonymity in the event of written publication of this research. My interviewer may disclose essential information about me to other people if it is necessary to protect my safety or that of others.

Questions. If I have questions about my participation in this study or about the study itself, I may contact Anthony Pavlo at 529-0193 (pavloaj@muohio.edu), or Dr. Larry Leitner (faculty advisor) at 529-2410. If I have questions about my rights as a research participant, I may contact the Office for the Advancement of Research and Scholarship at 529-3734 (humansubjects@muohio.edu).

Compensation. I will not be paid for my participation in this study.
I have read and understand the above information and I agree to participate.

I give my permission for the researcher to quote from my interview responses I contribute, verbatim, in part or in whole in any reports of this research (including papers presented at professional conferences, articles in professional journals, or book chapters). I am free to withdraw this consent at any time for any reason. There is no penalty associated with withdrawing this consent.

By signing below, I am indicating: (1) that I am at least 18 years old, (2) that I am voluntarily agreeing to participate in this study, and (3) that I understand that my responses will be kept confidential.

________________________________________
Signature of Participant                       Date
Appendix B
Debriefing

Thank you for your participation in today’s study. Much of clinical psychology is concerned with the conceptualizing and diagnosing human struggles. The purpose of this study is to gain a better understanding of the nature of diagnostic conceptualizations and, more specifically, its effects on clients. While much research has been conducted from the point of view of the clinician, much less has focused on the clients’ perceptions of their struggles. This research attempts to fill this gap by elucidating client’s perceptions of diagnostic conceptualizations and the clinicians that use them.

The most basic assumption of this research is that there are many ways to conceptualize human experience. While this difference exists, this does not mean that one conceptualization is better or more accurate than another. This assumption implies that many systems can capture some facet of human experience. Within this framework, it is important to understand that the conversations that took place today are not meant to diagnose. Instead, the researcher hopes that participants will leave this study with the knowledge that diagnostic systems are fallible and the ability to converse with their therapists about various diagnostic conceptualizations. Additionally, the researcher hopes that participants will not feel they now have one diagnosis or another. If this conversation has caused you any distress, please discuss it with the researcher or your current therapist.

If you have any questions or concerns about this research, please contact Anthony Pavlo at 529-0193 (pavloaj@muohio.edu), or Dr. Larry Leitner (faculty advisor) at 529-2410. If you have questions about your rights as a research participant, please contact the Office for the Advancement of Research and Scholarship at 529-3734 (humansubjects@muohio.edu).

Thanks again for your participation.
Appendix C

General Notions of Psychological Disorder

1) In general, how do you understand psychological disorders?
   a. How have you come to this understanding?

2) What should the role of the therapists be in helping people that come to them?

How the Person Understands Her/His Disorder in Relation to Each Diagnostic Scheme

3) How does the first (DSM) conceptualization describe your strengths and weaknesses?

4) How does the second (experiential constructivist) conceptualization describe your strengths and weaknesses?
   a. Which conceptualization do you prefer?
   b. What would you add to the first conceptualization that would make it accurately reflect what you feel (struggle with)?
   c. What would you add to the second conceptualization that would make it accurately reflect what you feel (struggle with)?

5) How does the first conceptualization help you see yourself in the future?

6) How does the second conceptualization help you see yourself in the future?
   a. Does one conceptualization give you more hope than the other?

7) How does the first conceptualization make you feel about personal change?
   a. What would these changes be?
   b. Do you think this is possible?

8) How does the second conceptualization make you feel about personal change?
   a. What would these changes be?
   b. Do you think this is possible?

9) How would hearing the first conceptualization at the inception of therapy affect your therapy?

10) How would hearing the second conceptualization at the inception of therapy affect your therapy?

11) Do you feel comfortable with the first conceptualization being disclosed to third-parties (e.g. insurance, employers, etc.)?

12) Do you feel comfortable with the second conceptualization being disclosed to third-parties?
Representation of Therapist

13) If you had not met a therapist face-to-face, and the only information you knew about him or her was that he or she used the first conceptualization, what would you think of the therapist?
   a. How well does this therapist understand you?
   b. Would you feel victimized?
   c. Does this therapist trust your experience of your struggles?

14) If you had not met a therapist face-to-face, and the only information you knew about him or her was that he or she used the second conceptualization, what would you think of the therapist?
   a. How well does this therapist understand you?
   b. Would you feel victimized?
   c. Does this therapist trust your experience of your struggles?

15) Would your thoughts about your therapist change depending on which description they used?

16) How do you think a therapist using the first conceptualization sees your ability to change?

17) How do you think a therapist using the second conceptualization sees your ability to change?

Client-Therapist Relationship

18) Would a therapist using the first conceptualization be effective for you?
   a. For people generally?

19) Would a therapist using the second conceptualization be effective for you?
   a. For people generally?

20) With which therapist do you think you can share more personal information with?

21) Would you trust a therapist using the first conceptualization?

22) Would you trust a therapist using the second conceptualization?

23) Do you think your therapist would be limited in her or his understanding of you if using the first conceptualization?

24) Do you think your therapist would be limited in her or his understanding of you if using the second conceptualization?
25) Your therapist conceptualized your struggles according to the first model. Does what you say about your experience influence how your therapist continues to conceptualize your struggles?

26) Your therapist conceptualized your struggles according to the second model. Does what you say about your experience influence how your therapist continues to conceptualize your struggles?