PSYCHOANALYTIC PSYCHOTHERAPISTS' EXPERIENCES OF WORKING WITH PSYCHOTIC PATIENTS

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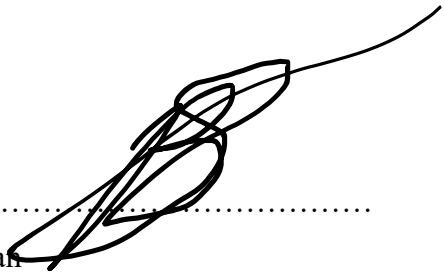
Declaration

I declare that this is my own unaided work. It is being submitted for the degree of PhD in Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at another university.



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Abstract

Therapeutic interventions with psychotic patients remain for many both a controversial and confusing area of clinical work. Yet there is very little research that has systematically investigated the experiences of psychotherapists concerning their engagement with psychotic phenomena. The established corpus of psychoanalytic theory proposes that managing countertransferential responses to a patient's psychosis is a crucial component of the therapeutic process. In line with this view the aim of this study was to explore psychoanalytic psychotherapists' experiences of countertransference when working with psychosis. Semi-structured interviews were conducted with eight psychoanalytic psychotherapists. Case material from my own clinical practice was also included. Various countertransference experiences are identified and linked to particular psychoanalytic notions of psychotic phenomena. These include: The strangeness of psychotic language use and the psychotherapist's confused grappling with psychotic transference; The psychotherapist's experiences of psychological and somatic disturbance in relation to psychotic projections; The psychotherapist's experience of relatedness when engaging withdrawn psychotic patients and the ensuing discomfort, frustration, and fatigue; And the centrality of the therapeutic relationship, and how the relationship as well as the psychotherapist are affected when the psychotic patient subjugates the therapist via a paranoid delusion. The psychotherapist's experiences are analysed and used to consider how psychosis can be treated within a psychoanalytic framework. The conclusions drawn suggest that psychotherapists who work with psychosis can have profoundly disturbing experiences that include: The fear of being overwhelmed; A failure of self-reflective function; The fragmentation of reality-testing; Intense bodily sensations; The frustration of interpersonal needs; and The loss of subjectivity.

Keywords; psychosis, psychoanalytic psychotherapy, countertransference, psychotherapist experience, therapeutic relationship, subjectivity

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Completing this thesis has been one of the hardest things that I have ever done. I wanted to know why psychotherapists avoid working with psychosis, and the answer came with much weight. The process took me to the borders of my own sanity, and I want to express my gratitude to those who joined me in the disturbance:

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Lastly, Elli, my wife, you know what you did…

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CHAPTER 1

Introduction

It has been well established in psychoanalytic literature that working with psychosis can be a profoundly complicated and challenging task for psychotherapists (Bion, 1957; de Masi, 2009; 2020; Schwartz & Summers, 2009; van Bark, Wolberg, Eckardt, & Weiss et al., 1957). For the psychotherapist, the work can be complex, confusing, disturbing, and at times overwhelming (De Masi, 2009). Further complexifying the matter is the fact that the very legitimacy of engaging therapeutically with psychotic patients has often been drawn into question (Bion, 1957; De Masi, 2020; Freud, 1924a/b; Kingdon, 2004; McGorry, 2002; Saayman, 2016; Steinman, 2009). This is in part as a result of the typical use of antipsychotic medications for treatment, rather than psychotherapy, as there are many who view therapeutic interaction with psychotic patients as counterproductive (Lehman & Steinwachs, 1998; Lucas, 2003; Saayman, 2011; Steinman, 2009). Yet, given the complexity of engaging psychotherapeutically with psychosis, there are very few examples of literature that focus on the experiences of the psychotherapist. In contrast, there exists a large body of in-depth psychoanalytic literature that focuses on understanding psychosis, how it develops, what it is that psychotic patients need, and different methods of therapeutic intervention. Although some of the literature does include the effects of the patient's psychosis on the therapist's thinking and ability to engage, there are very few experience-near accounts of what therapists encounter when working with psychosis.

There are numerous psychoanalytic papers on a vast range of psychological afflictions and therapeutic mechanisms that focus on therapists' experiences of engaging with their patients' psychopathology (Buechler, 1998; Coburn, 1998; Davies, 1999; Eekhof, 2018; Eulert-Fuchs, 2020; Hepburn, 1992; Hoffman, 1983; Horlick, 2006; Lijtmaer, 2010; Schachter, 1990; Shapiro, 2009; Skolnikoff, 1993; Spillius, 1992; Stern, 1989; Teitelbaum, 2003; Wilner, 1998; Wilner, 2006; Zuckerman & Sinsheimer, 2007). Yet there are very few papers that focus on the therapist's experience of the psychotic patient's psychopathology specifically, leaving an important area of therapeutic encounters largely unexplored. One such paper by Connolly and Cain (2010) that focused on therapists' experiences of positive countertransference when working with psychosis highlighted the therapists' experiences of strong rescuer fantasies, fatigue and burnout, disruptions in attachment, and loosening of inhibitions. The Connolly and Cain (2010) paper is also one of the few reports that are not based on case studies, but on interviews with therapists.

There are many examples of psychoanalytic studies that explore the psychotherapist's countertransference in relation to a wide variety of psychopathology (e.g. Buechler, 1998; Coburn, 1998; Davies, 1999; Eekhof, 2018; Eulert-Fuchs, 2020; Hepburn, 1992; Hoffman, 1983; Lijtmaer, 2010; Schachter, 1990; Shapiro, 2009; Skolnikoff, 1993; Spillius, 1992; Stern, 1989; Teitelbaum, 2003; Wilner, 1998; Zuckerman & Horelick, 2006). The psychoanalytic psychotherapist's exploration of their own countertransference makes up a crucial part of how they make sense of the patient (Arieti, 1957; Benedetti, 1999; Bion, 1954; Kernberg, 2003). This is no less true in relation to working with patients suffering from psychosis (Searles, 1975).

In this thesis my aim was to explore the countertransferential experiences of psychoanalytic psychotherapists who work with psychosis in an attempt to begin to elucidate particular dynamics that may emerge between the psychotherapist and psychotic patient. The exploration of the psychotherapist's experiences, including my own, offered me the opportunity to engage psychoanalytic theoretical constructs in relation to actual experiences in an attempt to gain more understanding as to why psychotic illnesses are not typically treated with psychotherapy in South Africa, and in many other parts of the world. It also provided an opportunity to form more nuanced understandings of the experiences of the patient, of the nature of psychotic defences and their typical consequences, and of how the therapeutic process with a psychotic patient potentially differs from therapies with more neurotic patients.

Aims

The aims of this thesis developed from a position of political advocacy to one of clinical curiosity. The overall aim of this research was to explore the experiences of South African psychoanalytically oriented therapists when working with psychotic patients. This overall aim was further divided into three sub-aims. These aims highlight the importance of the interplay between the patient, the therapist and the therapeutic process; they also foreground the importance of understanding both psychotic and non-psychotic processes in this interplay. This latter emphasis is included in the research in order to capture the complexity of the therapeutic experience. The sub-aims were to:

1.) Explore psychodynamic psychotherapists' understandings and experiences of their psychotic *patients'* relationship to their own reality (both psychotic and non-psychotic)

2.) Explore psychodynamic psychotherapists' understandings and experiences of *themselves* in psychotherapy with psychotic patients (including both psychotic and non-psychotic responses)
3.) Explore psychodynamic psychotherapists' understandings and experiences of the *therapeutic process*, given its different rules of engagement compared to working with other kinds of patients

These aims guided the research via a combination of case study research based on my own therapeutic encounters with psychotic patients and interviews with psychoanalytically orientated psychotherapists who have worked with psychotic patients (i.e. patients who actively experience psychotic symptoms not only in the transference but also in everyday life).

Research questions

Given the relatively limited literature exploring therapists' experiences and understandings of working with psychotic patients, research questions were formulated broadly. Under each research question, more specific possible foci were highlighted. These foci were further refined as guided by the interview data.

1.) How do psychodynamic psychotherapists understand and experience their psychotic *patients'* relationship to their own reality (both psychotic and non-psychotic)?

This research question included an exploration of therapists' experiences of patients' various symptoms; of patients' tolerance of and response to the therapeutic process; of the patient's contribution to experiences such as meaninglessness or terror; and of how therapists experience the interplay between patients' psychotic and non-psychotic moments and communications.

2.) How do psychodynamic psychotherapists understand and experience *themselves* in psychotherapy with psychotic patients?

This research question included exploration of the therapists' experiences of themselves both positively and negatively in relation to their patients; of the aspects that attract them to or repel them against this kind of work; of their countertransference responses to patients' symptoms and experiences in the therapeutic encounter; of the cumulative repercussions of working with psychosis; and of therapists' own engagements with potentially psychotic and non-psychotic parts of themselves.

3.) How do psychodynamic psychotherapists understand and experience the *therapeutic process* of working with psychosis, specifically in terms of how psychotherapists determine the suitability and usefulness of specific approaches to psychotherapy with psychotic patients?

This research question included an exploration of therapists' understandings of: What works or fails to work in therapy; their understandings of the quality and implications of the therapeutic alliance; their formulation of therapeutic goals; their understanding of the repercussions of the different rules of engagement inherent in the therapeutic process; the repercussions of engaging with the patient's psychotic experience; and their understanding of the role of their own potentially disturbing experiences in the therapeutic process.

Rationale

It can be argued that psychosis represents psychopathology at the most severe level of fragmentation of the self and the breaking with reality (Bion. 1957; de Masi, 2009; 2020; Freud, 1924 a/b; Klein, 1946; Schwartz & Summers, 2009). Psychosis frequently leads to the patient experiencing their engagement with the world from a terrifying and confusing internal place (Garfiel & Dorman, 2009; Klein, 1946; Schwartz & Summers). The severity of breakdown in interpersonal and professional engagement is profound, and the likelihood of the patient's physical and mental survival can plummet as the illness progresses (Faulconer & Silver, 2009; Rössler, Salize, Os, & Riecher-Rössler, 2005). Yet there appears to be a relative paucity of literature in the area of how *psychotherapists* experience engaging with patients that suffer from this devastating disorder.

There are many factors that could inform the psychotherapist's experiences of working with psychosis, for example; the therapist's understanding and experience of their patient's madness, the therapist's understanding and experience of their own capacity for madness, as well as the complete reversal and undoing of the common rules of engagement in psychotherapy and the repercussions of engaging with psychotic disturbance (Bion, 1957; Hill, 1955; Ogden, 1979). When one proposes that psychotic patients stand to benefit from psychoanalytically informed psychological interventions, both objection and support appear to bring with them numerous assumptions (Kennard, 2009; Lehman & Steinwachs, 1998; Robins, 2002). The psychotic patient's 'hallmark' tenuous ego boundaries, hatred and fear of reality, inability to tolerate ambiguity, and chronic failure to relate 'meaningfully' to others are often

amongst the first features of presentation that promote arguments cited against psychoanalytically informed psychological interventions with this patient group (Bonnigal-Katz, 2019; Freud, 1924b; Hill, 1955; Robins, 2002; Saayman, 2011; Steinman, 2009). However, two questions seem to follow: Firstly, whether these objections actually speak to psychotherapists' experiences of this type of work; and secondly, whether there are not aspects inherent in this type of work that, on some level, lead to psychotherapists avoiding therapeutic engagements with psychotic patients (Steinman, 2009). These questions speak directly to the aims of this research, and will be explored against the background of the existing body of psychoanalytic literature on the experiences of psychotherapists who engage with psychotic patients.

Much has been written on the therapist's experience of patients who present with non-psychotic symptoms. There is, however, comparatively little written on therapists' experiences of working with patients suffering from psychosis, particularly from a psychoanalytic perspective. Even less has been written on therapists' experiences of their own internal disturbances when doing this type of work. Those papers that do provide accounts of the effects of the patient's psychosis on the therapist and on the therapeutic engagement are, however, very illuminating. Some of the accounts that I have come across do much to illustrate how essential an understanding of the therapist's experience of their patient's psychosis (or their own) is to the process of establishing a relationship and meaningfully engaging with their patient's communications, although these accounts are rare (Hazan, 1988; Martindale, 2017).

Neurotic patients often locate their therapists as receptacles for projections, and this also occurs with psychotic patients. What is often different for psychotic patients is the extent to which the projections are fragmented, and the therapist's subsequent confusion as to what, when, where, and who is being experienced or represented in the transference (Koehler, 2009; Searles, 2012). Therapists' experiences of psychosis can be extreme – ranging from a complete absence of experience, to a witnessing of the patient's psychic death without it culminating in the loss of actual life (Hazan, 1988). Being rendered a witness to one's patient's psychic suicide can evoke powerful feelings of guilt (precipitated by a sense of omnipotence), helplessness (omnipotence proved false), and anger (Hazan, 1988). Since the patient is still alive, the therapist remains active in a therapeutic exchange, one that now sets the stage for the guilt to be enacted when the patient is in pain, anger when they do not cooperate, and helplessness when they regress (Hazan, 1988).

What is needed from the psychotherapist is a type of secretarial task, an organizing function as they attempt to help their patient link affect to experience, and sort out actual experiences and thoughts related to objects (Eigen, 1993). However, therapists can only undertake this task to the extent that they can allow themselves to become saturated with confusing projections (De Masi, 2020; Faulconer & Silver, 2009; Hazan, 1998; Müller, 2004). Often these overwhelming experiences result from an engagement with communication from the patient that stands in the service of not-thinking, and unformulated experience that comes to be expressed through symptom-formation that often includes the patient's (and possibly the therapist's) agoraphobia, murderous rage, fear, panic, and strong sexual urges (Lippencott, 1990). These intense experiences can make it extremely difficult for the therapist to keep their own thinking from becoming fragmented (Lippencott, 1990). Despite this, the patient may very well entertain a hope that the therapist will not only hold the corresponding emotion for them, but also experience it as their own – stepping further into the patient's confusing reality, a reality infused with doubt as to what does and does not belong to oneself (De Masi, 2020; Eigen, 1993; Gibbs, 2009; Hazan, 1988; Hill, 1955; Schwartz & Summers, 2009).

As stated earlier, Ogden (1979) reflected on the experience of one of his psychotic patients, describing the communication as meaningless in the sense that it appeared to lack coherent representation of the patient's internal process. The meaninglessness does not signify an absence of the therapist's experience, yet the process to determine what the therapist does in fact experience - whether it originates from the psychotic patient, the therapist, or the intersubjective space between them - seems an elusive one (Grotstein, 1977b). The therapist needs to work hard to refrain from succumbing to an experience of the psychotic patient's autistic communications as seemingly unreal and empty, and needs to try to convey to their patient that they do take them seriously (John, 2001; Schwartz & Summers, 2009). This sense of meaninglessness can easily act as a very powerful defense against an experience of real pain and suffering - however obscured and fragmented - originating from the patient's very real psyche (John, 2001). Clearly it can become confusing for the therapist who is trying to make sense of their experience of the patient's psychosis (or their own), whether during the session or after. Here psychoanalytic concepts such as transference and countertransference can be incredibly helpful to render the therapist's reality more understandable (Eekhof, 2018; Goldberg, 1979).

Without getting lost in the controversy involved in defining these terms, Goldberg (1979) made the important distinction between neurotic transference and psychotic transference - viewing the former as being directed at the therapist's mind to be thought about, and the latter at the therapist's body to be experienced. Goldberg (1979) understood this difference as signifying the need for an additional step in trying to understand the therapist's functions when working with psychosis. She essentially stated that the therapist's experience of countertransference is dependent on the patient's level of integration, leading to more unsettling and disturbing experiences with typically un-integrated sufferers of psychosis (Goldberg, 1979). Koehler (2009) underlined the importance of the development of psychotic transference between therapist and patient, as this allows for the level of communication that corresponds with the psychotic patient's state of un-integration.

Consequently the therapist may find themselves (be it during the session or retrospectively in supervision) becoming intensely paranoid as they experience overt or latent fears of being persecuted as a result of an experience of un-integration (Müller, 2004). Narcissistic psychotic transferences can give rise to symbiotic relationships whereby the therapist may become unable to distinguish between their patient's progress and their own (Müller, 2004). Narcissistic psychotic transference often overlaps with confusional-state psychotic transference as it also pushes for a merging of self and other (Müller, 2004). These various forms of transference illustrate the importance of distinguishing between subjective countertransference - the therapist's own reactions that are largely independent from the patient and the process - and objective countertransference resulting from the therapist's physical and mental reactions to the process and the patient (Müller, 2004).

As mentioned earlier, Connolly and Cain (2010) explored therapists' experiences of positive countertransference when working with psychotic patients. This paper, which is derived from an interview-based study, showed how therapists reported experiencing strong rescuer fantasies, fatigue and burnout, disruptions in attachment, and loosening of inhibitions (Connolly & Cain, 2010). Spotnitz (1983) focused on how therapists experience and engage with psychotic patients' anger and aggression, stating that the working through of the positive analytic countertransference with psychotic patients is only possible if the therapist can hold the patient's anger. Spotnitz (1983) explained that, in order for the positive countertransference to be successfully resolved, the patient needs to be allowed an experience of "*healthful, genuine, aggressive emotional interchange (HGAEI)*" (p163.). This implies that the therapist

needs to be able and willing to suspend emotional empathy lest the patient's developmentally curative need to engage in an aggressive manner is frustrated (Spotnitz, 1983). However, this suspension cannot be achieved without an already established relationship that contextualizes it and renders it safe, a relationship that is partly made up of brave and honest communication from the therapist who illustrates the full range of human emotion (Spotnitz, 1983). The therapist's willingness to allow for anger being experienced as murderous, love as intensely and solely sexual and transgressive, closeness as claustrophobic, and disappointments as signalling suicidal and catastrophic consequences, is vital if the psychotic patient is going to experience the therapeutic relationship as a means to a discovery of their internal world (De Masi, 2020; Liegner, 2003). If the therapist can allow themselves to experience their psychotic patient's reality, to be disturbed by it, they provide their patient with an experience of having an impact on someone else in reality, an experience that may signal the beginnings of a sense of agency (De Masi, 2020; Summers, 2009).

The importance of researching psychotherapists' countertransferential experiences when working with psychotic individuals hinges on the following two notions: Firstly, very little psychoanalytic research has been done on this topic, which in and of itself is an interesting phenomenon which potentially speaks to countertrtansferential reactions to the topic of psychosis. Secondly, a true deepening in the psychotherapist's psychoanalytic understanding of psychopathology is frequently aided by the psychotherapist's honest and often courageous exploration of their countertransferential reactions to their patients (Eulert-Fuchs, 2020). Thus building on the existing body of psychoanalytic knowledge on how psychotherapists may potentially experience engaging with psychotic patients, specifically via their countertransference, is useful in that it stands to inform how psychotherapists understand, approach, and make sense of psychotic individuals via theoretical notions that have been linked to clinical experience.

Theoretical orientation and conceptual framework

A psychoanalytic perspective on psychosis does much to help us understand how this condition develops, and how it may be treated (De Masi, 2020). It highlights the many intricate dynamics involved, from the therapist's experience of fragmentation to the patient's reestablishment of self. In the service of the further development of theory and practice that is informed by therapist's actual experiences of these theories and practices, this thesis aimed to add to the few

experience-near accounts of what it is like to work with someone else's psychosis, as well as how this process affects the psychotherapist's capacity to accept and tolerate disturbing experiences.

Psychoanalytic Perspectives on the Nature and Treatment of Psychosis

The purpose of the literature review will be to locate and position the proposed study in the area of psychoanalytic accounts of working with psychosis, with a particular focus on therapists' experiences. To avoid repetition, some of the influential psychoanalytic concepts that have guided this study have not been included in the literature review below, as these theoretical concepts are integrated in the four standalone journal articles that follow.

The rich body of psychoanalytic accounts of understanding, formulating, and working with psychosis includes the works of Bion (1957, 1978), Eigen (1993), Freud (1924a, 1924b), Fromm-Reichmann (1948), de Massi (2009;2020), Hill (1955), Kernberg (1986), Klein (1946), Lacan (1953), Ogden (1979), Rosenfeld (1952a), and Searles (2012). The psychoanalytic theorists that have been drawn upon in this research offer specific understandings of the development and nature of psychosis, and of the patient's subjective experiences of psychosis. These understandings include what it means to have a mind – what is required, in the developmental sense, for an individual to end up with the capacity to think. It includes an understanding of subjectivity, of the processes that contribute to the construction of self and the capacity to acknowledge and represent one's 'self'. Theorists that focus on the psychotherapist's experiences of working with psychosis (such as Searles) have also been included. I will briefly touch on why theorists foundational to this study have been selected.

Freud's (1924a) views on the differences between neurosis and psychosis provide the basis for assuming a stark contrast in the levels of therapeutic engagement between neurosis and psychosis respectively. More specifically, Freud (1924a) differentiated between neurosis and psychosis by stating that in neurosis the patient's principal conflict would be between the id and the superego, whereas in psychosis the conflict would be situated between the ego and reality itself. Freud (1924a, p.149) explained that, in acute hallucinatory confusion, "either the external world is not perceived at all, or the perception of it has no effect whatsoever". One then wonders what the therapeutic implications are for engaging with a patient who suffers from this specific conflict - between their id and reality - and what the effects of experiencing this type of pathology might be on the therapist as well as on the therapeutic process. For

example, the differing functions of interpretation in working with a neurotic and a psychotic patient illustrates the importance of this question. In the case of the neurotic patient, it would be to render unconscious material conscious (Koehler, 2009). In the case of a psychotic patient, interpretation would be directed to helping the patient to discriminate between self and other (Koehler, 2009).

Freud (1924b) felt that psychosis cannot be fully understood outside of the context of a sound understanding of neurosis and vice versa, an idea that he clearly illustrated when he juxtaposed these two states. Showing how both neurosis and psychosis aim to modify reality, Freud (1924b) suggested that a less severe break with reality is at play in neurosis. In further clarifying the differences between neurosis and psychosis, Freud (1924b) described a case of a young woman who fell in love with her brother-in-law. The level of defence that might be operating in such an individual and might point to the level of pathology involved is highlighted as the woman experiences intense guilt when her sister dies, and the object of her infatuation is made available (1924b). Freud (1924b) indicated that were she neurotic, she could have responded by repressing her desire for the man, and denying the possibility of a union or fulfilment of her wish. However, were she psychotic, she could have denied the fact of her sister's death altogether (Freud, 1924b). In this case the therapist would be confronted with working with the replacement and reparation of the rejected reality, the delusion (Freud, 1924b). It is precisely this difference in where the focus of the reparation might lie that serves as a potent comparison between neurosis and psychosis, as in both cases the function of the response is to make good the loss in reality, and the resulting frustration of the id (Freud, 1924b). Freud (1924b) goes on to explain that:

> *...both neurosis and psychosis are thus the expression of a rebellion on the part of the id against the external world, of its unwillingness - or, if one prefers, its incapacity - to adapt itself to the exigencies of reality.* (p.185)

However, the differences between these two states become even more evident in exploring how the ego facilitates this rebellion, in the case of neurosis in the form of a flight from reality, whilst in the case of psychosis, in the form of a replacement thereof (Freud, 1924b).

According to Klein (1946), the ego's defensive ability to replace reality stems from the need to respond to a developmental failure in infancy. She proposed this view within the context of her

belief that object relations are present from the beginning of the infant's life (Klein, 1946). Klein (1946) termed these very early years of development the paranoid phase, a phase that has as one of its principle objectives the working-through of the infant's persecutory fears that stem from what it dreads may result from sadistic attacks on the mother. Failure to work through this phase may lead to a "*regressive reinforcing of persecutory fears"* and a subsequent "*strengthening of the fixation points for severe psychoses"* (Klein, 1946, p.100). Klein (1946) explained that this kind of failure expresses itself in the schizophrenic adult's life through the savage splitting of the self and via intense projection. The failure of development is then ultimately that the individual never arrives at the depressive position – a developmental milestone that makes it possible to respond meaningfully to guilt, fear, anger, and disappointment (Klein, 1946). Entering into the depressive position establishes one's ability to think despite painful emotional experience, instead of resorting to an attempt at remaking reality (Klein, 1946). These views underpin the understanding that when psychotic patients regress, they do not revert to archaic ideas, but to archaic ways of thinking (Faulconer & Silver, 2009).

In his paper '*A Psychoanalytic Study of Thinking'* Bion (1962) expanded on Freud's (1924a; 1924b) and Klein's (1946) ideas on the psychotic patient's failure to work through the paranoid position, and the consequent negative effects on the ability to regulate one's affect and employ thinking to manage thoughts. Bion (1962) did so making reference to his theory that all human beings contain within them a non-psychotic part as well as a psychotic part, and that the infant's developmental circumstances and associated experience dictate which part will likely dominate. Broadly speaking, the developmental experience is driven by excessive projective identification as a primary means of unconscious communication (Klein, 1946). Bion (1962), in disagreement with Klein (1946), viewed this excess as developmentally appropriate as it leads to the development of healthy communication, whilst potentially serving a necessary evacuative function. If this process goes wrong, if the mother is not able to hold and render palatable the infant's aggressive projections, the infant is faced with the internalization of an "*object which starves its host of all understanding"* (Bion, 1962, p.308). The implication of this developmental failure is that the individual does not adequately develop the capacity for thinking, as the individual's primary narcissism is developmentally unresolved and remains fixated (Fromm-Reichmann, 1948). Fromm-Reichmann (1948) reflected on Freud's (1914) views on narcissism, stating that unresolved primary narcissism was one of the reasons why Freud viewed the formation of a therapeutic relationship with a psychotic patient as unlikely. However, Sullivan (1966) argued that there is no developmental stage where an individual

functions outside of the sphere of interpersonal relatedness, thus suggesting that the psychotic patient's defensive wish to refrain from relating makes the establishment of a therapeutic relationship difficult, but not impossible (Koehler, 2009). Fairburn (1944) also made the important observation that the psychotic patient never fully relinquishes their ability to relate to others or to themselves (Gibbs, 2009). Fromm-Reichmann (1948) emphasized the defensive nature of the wish for isolation, stating that the psychotic patient does *not* withdraw freely, and that this can be seen in the patient's ambivalent and paradoxical attempts at relatedness and withdrawal, a dynamic that frequently robs psychotic communication of apparent meaning and is likely to manifest in therapy (Gibbs, 2009). The preceived 'meaninglessness' that can characterize the psychotic patient's communication can bring forth many challenging dynamics during the course of treatment.

Some psychoanalytic writers reflect on the phenomenon of meaninglessness in psychosis and its potential effects on the patient and the therapist. Ogden (1979, p.519) wrote of his experience of one of his psychotic patients, stating that *"the meaninglessness was not experienced because nothing was experienced: it was meaninglessness that did not feel meaningless, since there was no capacity to feel or to experience anything"*. Grotstein (1977b, p.434) stated that the psychotic patient "*simply cannot know how he feels about anything… in order to defend himself against pain",* and that the psychotic patient *"attacks his own ability to feel"*. These writers are not reflecting on a lack of experience, but on non-experience, a meaninglessness that the therapist must bear in order to make relating possible (Faulconer & Silver, 2009).

Reflecting on the difficulties involved in aiding the psychotic patient's attempts at communication Lacan (1953) viewed the role of the therapist as that of facilitator, rather than interpreter (Schwartz, 2009). This would include the idea that a patient suffering from psychosis operates outside of discourse despite using understandable language, as the meanings attributed to certain words or concepts are not necessarily shared by those involved in the conversation (Lacan, 1953; Schwartz, 2009). In line with Freud (1924a/b) and Bion (1957), this substitution in meaning is understood to stem from a foreclosure in thinking, an unwillingness and inability to consider a threatening meaning which is subsequently replaced with a delusion that represents something more manageable in the patient's symbolic system (Bion, 1957; Freud, 1924a/b; Lacan, 1953; Schwartz, 2009). Lacan (1953) viewed the therapist's response to psychotic communication as that of secretary and active listener, of one

who clarifies and accepts the psychotic patient's communications, rather than assuming the role of decoder, as the latter can come across as persecutory (Schwartz, 2009). Essentially the therapist aims to brace the patient's delusional system as a bearable point from which to engage the world, but does so with a patient who does not possess the reliable tools for communication (Schwartz, 2009; Searles, 2012).

The danger exists that the therapist could become distracted by communication that seems inherently meaningless, rather than attempting to appreciate the possible defences that the apparent meaninglessness may be obscuring (Searles, 2012; Steinman, 2009). These defences could include displacement, projection, introjection, condensation, and isolation (Searles, 2012). Whilst reflecting on these defences and their various forms of manifestation, Searles (2012) also stated that these defences represent the overt manifestations of psychosis, and that one has to give careful consideration to the underlying psychodynamic processes that contribute to and necessitate psychotic communication. These processes would include: the patient's regression to an early level of ego functioning – a phenomenon that largely accounts for the concretization of the patient's thinking; severe low self-esteem, detectable in the physical manner in which psychotic patients often present and carry themselves; powerful ambivalence that is expressed through indirect communications, self-contradictory statements, and a disjunction in verbal and emotional expression; an incredibly harsh and punitive super-ego; and the aim to establish a symbolic infant-mother style of relatedness with the therapist (Searles, 2012). Searles is one of the few psychoanalytic theorists who focussed on understanding and treating psychosis via the notion of countertransference. In order to avoid repetition I will not expand on Searles' work here as many of his concepts are used in the standalone papers that follow, specifically in papers two and three.

The importance of using the idea of countertransference when researching psychosis rests firstly on the notion that it allows for an in-depth exploration and understanding of psychopathology, specifically via the clinical experiences of practitioners coupled with established psychoanalytic theory, and secondly on Gabbard's (1995) idea that countertransference is a unifying concept. Specifically useful to this thesis is Gabbard's (1995) explanation that countertransference is a collaborative creation between the psychotherapist and the patient, with varying degrees of how the extent and nature of the respective contributions would be determined based on theoretical orientation.

When using countertransference to make sense of the patient's difficulties, it is important that the psychotherapist does not fall into the trap of solely holding the patient responsible for their own experiences of disturbances (Gabbard, 1995). Doing so fails to capture what is located in the psychotherapist that contributes to their experience of disturbance, what Gabbard (1994) refers to as the 'hook' to which the patient's projections attach. Gabbard (1995) goes on to say that:

> *"The pre-existing nature of intrapsychic defences and conflicts, as well as self-object-affect constellations in the internal world of the recipient, will determine whether or not the projection is a good fit with the recipient. Even when the countertransference response is experienced by analysts as an alien force sweeping over them, what is actually happening is that a repressed self- or object-representation has been activated by the interpersonal pressure of the patient, p.477."*

In line with Gabbard's thinking it would then follow that, in order to research psychotherapists' countertransferential experiences of working with psychosis, one has to hold in mind the complex and challenging task that the psychotherapist has to accomplish in order to provide an account of their experiences. They would have to be able and willing to explore their own experiences in a manner that renders them vulnerable to their own injuries, failings, and defences. To further complicate the matter, when allowing for these raw parts of themselves to be exposed and reflected on, these psychotherapists would be doing so in relation to patients who exhibit severe and often disturbing levels of psychopathology.

Structure of the thesis

The introduction of the thesis will be followed by Chapter Two, which outlines the research methods used as well as ethical matters. Chapters Three to Six are made up of the four journal articles that are required for the completion of the doctoral degree. All four individual articles have been published in peer-reviewed academic journals. The journal articles have been written to comply with the specific editorial requirements of the different journals. Each of these four chapters begins with an introduction that situates the article in relation to the broader aims of the thesis. Although these four chapters have different areas of focus, they are all concerned with the experiences of psychoanalytic psychotherapists who work with psychotic patients.

Chapter Three, the first of the four journal articles, is based on a clinical case study of a psychotic patient that I worked with in a government facility. My experiences of the therapeutic process are explored against the backdrop of foundational psychoanalytic theories of the development and treatment of psychosis. This chapter chronicles my own process of trying to make sense of how to work with psychotic patients in a meaningful way, using my own experiences as a lens. The themes of this chapter include: Language use in psychosis – the idea that, for patients suffering from psychosis, language is not necessarily used to communicate, that language can function as a replacement for action, or a as a substitute for thinking; the psychotic transference as it developed in the therapeutic relationship – the different ways in which the psychotherapist's experiences influence how the patient is understood and treated; and my own needs to feel valued and competent amidst very challenging circumstances.

Chapter Four continues to develop the general theme of the psychotherapist's experiences of working with psychosis, with a specific focus on experiences that may potentially disturb the psychotherapist. This chapter draws from interview material obtained from eight South African psychoanalytic psychotherapists who work with patients experiencing forms of psychosis. The participants' experiences of engaging with psychosis are explored via the idea that the psychotherapist can, at times, feel like some of the madness in the room is situated within themselves. The role of the psychotherapist's body and the phenomenon of somatic communications are also investigated.

Chapter Five builds on the idea that difficult and disturbing countertransferential experiences can potentially make working with psychosis challenging for psychotherapists. This chapter continues the analysis of data obtained from the interview material and focuses on the participants' experiences of working with patients who exhibit psychotic withdrawal. Establishing some form of relationship is a crucial part of the therapeutic relationship, a process that can become challenging and laborious when working with a very withdrawn individual. The psychotic and withdrawn patient's difficulties in relating are explored, as are the psychotherapists' own needs for relatedness. The chapter concludes with a discussion on how relatedness can be restored.

Chapter Six is based on clinical case material, in this instance a composite narrative based on a selection of patients that I have worked with in government hospitals and in my private

practice. The composite narrative presents a psychotic and delusional patient who has implicated me in her delusion as a malignant figure. The focus of this chapter is on the psychotherapist's experiences of being included in the patient's delusional construction. The chapter situates itself in influential psychoanalytic literature on how delusions are conceptualized and looks at how the development and experience of psychosis stands to denude and damage the patient's subjectivity and their ability to represent their subjective experiences. Delusions are presented as possible compensatory measures for patients who struggle to navigate their worlds due to a disturbed sense of subjectivity. The chapter explores my own experiences of being made part of the delusion. In exploring these experiences, I demonstrate the impact on my own subjectivity, as well as the resulting disturbances that I felt. Chapter Seven concludes with a discussion on how the psychotherapist can use their countertransferential experiences to hold some form of balance between two very different realities.

Chapter Seven, concluding the thesis, integrates the themes and arguments that develop throughout the preceding four chapters. Difficult experiences encountered by psychoanalytic psychotherapists when working with psychosis can possibly contribute to a deeper understanding of what is asked of the psychotherapist in this particular kind of clinical encounter. Furthermore, exploring the experiences of psychotherapists in their encounters with psychosis adds to a more nuanced conceptualization of what patients suffering from psychosis may experience, and of what they may need from the psychotherapist.
Chapter Seven also covers the limitations of the research as well as possible implications for future research.

Chapter 2: Research method and ethical considerations

Qualitative research

The study is qualitative in nature, as the focus of the research is on the nature, quality, and effects of therapists' experiences of working with psychosis. This approach allowed me to gain information of the participant's experience in the specific subjective context in which the experience occurs (Willig, 2001). A qualitative design also allows for the study of complex areas of psychotherapy, such as the therapeutic treatment of psychosis and the phenomenon of countertransference (Fossey, Harvey, McDermott, & Davidson, 2002). Inasmuch as the

responses of the research participants are subjective in nature, and are not based on simple, objective constructs, an interpretive research paradigm was applied (Scwandt, 1994). An interpretive paradigm accommodates the subjective nature of this research as it gives importance to the attempt to discover and understand the meanings of an individual's actions and experiences (Fossey et al., 2002). It also emphasizes the importance of providing accounts of these meanings from the perspectives and experiences of those involved, which is particularly important when researching countertransference reactions (Fossey et al., 2002). Semi-structured interviews with psychoanalytically-orientated clinical, counselling, and educational psychologists in South Africa were used in an attempt to determine their experiences of psychoanalytic psychotherapists that engage therapeutically with individuals suffering from psychosis.

I have also made use of case material, as case material when sufficiently formulated, not only tests psychoanalytic hypotheses but also potentially contributes to the generation of theory (Hinshelwood, 2010). The use of case studies also aids the exploration of clinical practice and thus serves the aims of this research in that it allows for a focus on specific psychoanalytic phenomena as encountered in the therapeutic setting (Bateman & Holmes, 1995; Midgley, 2006).

Data Gathering

Method 1: Participant selection and interviews

Non-probability purposive expert sampling was used. Expert sampling was indicated, as this ensured that psychoanalytically-orientated psychologists with adequate experience working therapeutically with psychotic patients were interviewed (Palys, 2008). A non-random sample also ensures investigation of the behaviour and experiences of a specific group, yielding information that will be more valuable than information obtained from a random group of individuals (McBurney, 2000). As is the nature of qualitative research based on interviews, I aimed to permeate social reality beyond the explicit meanings as presented by participants (Crouch, 2006). Thus, as the aim was to do an in-depth inquiry into the experiences of the participants, a relatively small sample size was warranted (Elliott, 2010; Crouch, 2006). A purposive sample of eight psychoanalytically-orientated clinical, counselling, and educational

psychologists were interviewed. The second and third standalone articles are based on the interview material, and include further details on this method.

Inclusion criteria comprised of the following: Registration with the Health Professions Council of South Africa (HPCSA) as a clinical, counselling, or educational psychologist at the time (but not limited to) at which the therapeutic work with psychotic patients was done; an openness to engaging therapeutically with psychotic patients; a psychoanalytically-informed approach to working with psychosis; and experience of engaging therapeutically with patients suffering from psychosis, irrespective of the duration of the therapy. Gender, race and age did not factor into the sampling criteria, as the research does not aim to determine the effects of these factors on working with psychotic patients. Participants were required to have at least three years of experience practicing independently at the time of the interview. This increased the likelihood of interviewing psychologists with a sufficiently formed capacity to formulate the various dynamics of the therapeutic process, as well as reflect on their own experiences of therapy with psychotic patients. Psychologists were invited to participate in the study via the South African Psychoanalytic Confederation (SAPC) network. The nature of the research, as well as its purpose, was explained in an email, with a subsequent request for participation (see Appendix B). In addition to this certain key figures in the field were contacted telephonically. The contact resembled that of the email sent via the SAPC. An information sheet containing my contact details, the details of the research, and the research procedure as it involved the participant were emailed to participants who were contacted telephonically (see Appendix B). Snowball sampling was also used in an attempt to reach other prospective participants via the key figures and their respective networks (Maree & Pietersen, 2010).

After consent had been obtained from participants (see Appendix C), I administered a self-designed semi-structured interview schedule (see Appendix A) in face-to-face interviews. The use of semi-structured interviews was warranted as it allows for a flexible interview with a conversational style (Whitley, 2013). This is advantageous when dealing with the participants' subjective experiences and attitudes, as it does not force them to answer in a specific format, and likely enables participants to relate their experiences of dealing with psychosis in a way that reflects their own reality (Whitley, 2013). Semi-structured interviews also enabled me to employ open-ended questions that allow for probing, which placed me in a position to procure increased understanding and richer information (Reja, Manfreda, Hlebec, &Vehobar, 2003).

All of the participants were based in Johannesburg (South Africa) at the time of the interview. The participants consisted of 4 males aged between 32 and 52 years of age, and 4 females aged between 35 and 62. Two of the male participants are registered as clinical psychologists, one is registered as an educational psychologist, and one as a counselling psychologist. All of the female participants are registered as clinical psychologists.

In terms of work context, two of the male participants work in government hospitals, and two work in private practice. Two of the female participants work in government hospitals, and the other two in private practice. All of the participants work within a psychoanalytic model.

Method 2: Psychotherapy Case Studies

The psychotherapy case study method allowed for an in-depth exploration of a specific phenomenon – the psychotherapist's experiences of working with psychosis, as it provided for detailed accounts of a particular psychological concept, how this concept unfolds in the treatment setting, and how this process is represented and made sense of in the specific context within which it occurred (Ivey, 2009).

The case study method was also used to test specific hypotheses and to further the description and elucidation of specific phenomenon encountered in working with psychotic patients (Whitley, 2013; Yin, 1993). For the first standalone paper the case material consisted of one of my own therapeutic encounters with a psychotic patient. This particular case has been sampled because it was a lengthy treatment for the setting (government psychiatric inpatient facility), included extensive case notes, and was closely supervised. Permission to use this material was obtained both from the patient and the treatment institution. The factors inherent in this type of work that received focus, such as the therapist's differentiation between psychotic and non-psychotic communication, as well as the therapist's experience of his own psychosis, were looked at within the context of whether and how they influence the entire therapeutic process. The selection of specific areas of focus aligns with Edwards' (2007) assertion that the psychotherapy case study method is to be understood as selective rather than exhaustive, and flexible rather than rigid.

The practice of focusing on specific areas of psychological phenomena extends to the fourth article. For the fourth article case material from my work with psychotic patients in private and

government settings were selected and used to construct a composite narrative in order to illustrate the psychotherapist's experiences of a specific psychological phenomenon. The cases that were selected to compile the composite narrative all speak to the psychotherapist's experiences of being implicated in a psychotic patient's paranoid delusion as a threatening figure. These cases were selected based on the criteria that they strongly exemplify the phenomenon to be explored (Yin, 1993). One of the aims of this paper was to contribute to the evaluation and development of practice in psychotherapy, which is why the case study method was indicated (Edwards, 2007). Paper four includes an expanded discussion on the use of composite narrative case studies.

Both papers one and four include vignettes with the aim of clearly illustrating a specific clinical understanding rather than proving theory with objective facts (Widlöcher, 1994). The material in both these papers was used in line with the following suppositions as outlined by Edwards (1998): The aim of this approach was not to arrive at predictions; quantification, despite being important, is not seen as an end in itself. The quality of data drives the quality of science, thus case study material, despite not being widely generalizable, provides quality data as it is in-depth (Edwards, 1998). Further the process of exploration and understanding is driven by the participant's account of their experiences; and the case material is viewed within the context in which it originated (Edwards, 1998).

Semi structured interviews

The interview schedule (Appendix E) consisted of 13 questions, and, based on the aims of the research, facilitated participants' accounts of; how they became involved in working therapeutically with psychosis; what their experience of this type of work is; what they find difficult about this type of work; what they find fulfilling about this type of work; and how they view and experience their own way of engaging with psychosis. The interview schedule was constructed with input from the research supervisor, and was designed in a manner that facilitated the collection of rich information based on the development of a relationship with the participants that allowed for flexibility (Mertens, 2005). The formulation of the questions was based firstly on psychoanalytic literature that focuses on countertransference phenomena in working with psychosis, secondly on personal curiosity about possible disturbances experienced by psychotherapists when working with psychotic patients, and thirdly in the service of developing academic thinking around how psychotherapists work with psychosis.

The format of the questionnaire was semi-structured, and allowed for dialogic interaction that aided participants in exploring their experiences on a deep level. Participants were encouraged to be self-reflective rather than to try to provide what might be considered to be correct answers to the questions. The questions were tested in a pilot interview conducted with a clinical psychologist in Johannesburg who has adequate experience in working therapeutically with psychosis. The interview style allowed for a back-and-forth process of discussion that facilitated the structuring of questions that maximized the exploration of the subject matter (Mertens, 2005). This process also allowed for attention to be given to the sequencing of the questions, as the question order may have influenced the interviewees' responses (Whitley, 2013). The psychologist who participated in the pilot interview was included in the study.

Each participant was interviewed at the practice where they worked from. All participants were interviewed once, as the material obtained did not warrant further inquiry. The interview times ranged between 90 and 120 minutes. The data was carefully reviewed to determine whether follow-up interviews were required since the effects of the interview process might have highlighted or changed the interviewees' perspectives on how they engage therapeutically with psychosis (Howell, 1997). After obtaining the participants' consent, all interviews were digitally recorded and transcribed (see Appendix D).

Data Analysis

Overall, an inductive analysis approach was used, rather than a deductive approach. This aided one of the study's main aims, which was to remain open to the participants' possible views and experiences, as well as ways of making sense of these without imposing specific prescriptions around what should or should not be experienced by psychodynamic psychotherapists when working with psychotic patients (Blackstone, 2012). An approach that allows for the data to direct the study was also warranted, as this was an exploratory study in an under-researched area. This does not, however, mean that the study does not include certain elements that represent a deductive analytic approach. These aspects include the understanding that working with psychotic patients is, in many ways, different to working with healthier patients. It also includes the understanding that even therapists may be susceptible to potentially disturbing and psychotic-like experiences when working with a patient's psychosis. It is understood that a complimentary relationship between inductive and deductive analysis approaches is possible,

as long as the researcher and research supervisor remain aware of the differences implied for each approach, and implements the two approaches in a manner that helps to control for conceptual blindness (Blackstone, 2012).

Interview data analysis

After the interviews were digitally recorded, they were transcribed verbatim. Thematic analysis was used in the identification of patterns and central themes (Coffey & Atkinson, 1996). More specifically, the analysis approach of Braun and Clarke (2006) was used in an attempt to report the interpretations, experiences, and definitive realities of the participants. I gathered sections of text under broad categories, and added provisional categories, after which these categories were refined in the search for emerging themes (Boyatzis, 1998). These themes rendered the large quantity of in-depth information that interview studies typically yield more manageable. The initial broader themes that were identified included; working psychosis as a representation of engaging with the most severe form of psychopathology; a lack of exposure to formal training in working with psychosis; differences in approach and technique between working with psychotic patients and working with patients that are more functional; the therapist being drawn to complicated and potentially disturbing encounters; the therapist's reflections on their own painful experiences; and the therapist's interest in psychosis. The next step was coding the data in order to link relevant responses to the determined themes, and to compare the responses (Braun & Clarke, 2006; Boyatzis, 1998). After the data had been coded and sorted into relevant themes, and had been reduced to a manageable size, I further analysed and interpreted the data. This entailed the meticulous reading of the initial coding categories to identify the main themes, which lead to the focusing of the analysis (Braun & Clarke, 2006; Sarantakos, 1998). This process rendered the initial broad themes more specific, and included; the psychotherapist's identification with the patient's experiences of psychotic symptoms; the psychotherapist's experiences of bodily symptoms when working with psychosis, which linked ideas around the particular nature of psychotic projections; the notion that some psychotherapists may avoid or be defended against the idea of engaging therapeutically with psychotic patients; and the psychotherapist's experiences of various forms of disturbance when working with psychosis, which included experiences of forms of their own madness. The final step in the analysis process was the overarching interpretation of the data, to a large extent grounding the data in the relevant psychoanalytic theory. Thus the data analysis was not a linear

process, as the research was driven by the participants' answers and the identified themes (Braun & Clarke, 2006).

Case study data analysis

The use of case material in combination with other methods, such as interviews, contributed to a multi-dimensional engagement with the material (Kohlbacher, 2006). Case studies have reputedly been the most appropriate methods for enquiry related to psychoanalytic technique (Hilliard, 1993). The single case study method also plays an important role in the generation of hypotheses and the development of theory (Kohlbacher, 2006). In line with this thinking the case material was analysed using qualitative interpretive thematic analysis, specifically theory-guided analysis. Thus the psychoanalytic theories on psychosis covered in the literature review, as well as others, were used to guide the interpretation of the case material. The integration of context was also important, as it was central to the process of analysing and interpreting the content. Awareness of the particular context of the case study data also served to emphasize latent content that potentially influenced the therapeutic process, as well as the researcher's and the reader's perceptions thereof (Kohlbacher. 2006). Both papers one and four ground the reader in the specific contexts within which the therapies occurred. The aim of the analysis of the case material was not to generate widely generalizable scientific information, but rather to provide an in-depth experiential account of the psychoanalytic perspectives on psychosis, linking this to the overall project (Edwards, 1998; Hilliard, 1993; Varvin, 2011). Thus the material was looked at through a lens that focused on the psychotherapist's experience, and was analysed based on clinical and psychoanalytic principles. The psychoanalytic and clinical principles that were used to analyse the data include: the interpretation (linking unconscious processes to conscious experience) of what the patient brings and how they respond to the psychotherapist's interventions; transference and countertransference phenomena, with a particular focus on the psychotherapist's responses; tracking both the patient's and the psychotherapist's emotional states; paying careful attention to overt and covert forms of communication; and tracking the patient's level of contact with reality, and the potential subsequent effects that this has on how the psychotherapist intervenes (Rustin, 2003).

The analytic process continued to inform the process of data analysis as the sessions were written up, which led to a further analysis and interpretation of the content of the therapy sessions. Particular emphasis was placed on: the nature of the patient's style of interaction and

approach to making contact with the psychotherapist; the specific and alternating versions of reality that the patient either created or responded to, as well as the psychotherapist's subsequent responses; as well as the psychotherapist's countertransferential experiences during the sessions.

The last phase of analysis consisted of engaging the material from a research perspective. This was achieved by linking the analysis of the material to the established psychoanalytic theory of the development and nature of psychosis, the treatment of psychosis, and the psychotherapist's countertransferential experiences. The process of analysis of case material was overseen and guided by the research supervisor, as well as the Ph.D. study group that consisted of other Ph.D. candidates and senior members of university staff.

Evaluating the quality of the research

In his book 'Greatness and limitations of Freud's thought', Eric Fromm (1980) reflected on the limitations of scientific knowledge and proposed the argument that every new theory is unavoidably faulty. He (Fromm, 1980) explained that this is not necessarily as a result of a lack of creativity, thoroughness, or ingenuity on the part of the researcher, but that it is the inherent consequence of a fundamental contradiction between two phenomena inherent in the process of developing novel theoretical thought. On the one hand, the researcher aims to add something new to the existing body of knowledge, and endeavours to do so via critical thinking that does away with illusions in an attempt to get as close as possible to an accurate representation of reality (Fromm, 1980). On the other, the researcher is bound to formulate and express their thought in the spirit of their context, influenced and guided by particular systems of logic, theoretical preferences, ideological inclinations, and their social milieu (Fromm, 1980). As it is unavoidable to use a particular understanding of and approach to generating, framing, and evaluating new knowledge, the best the author can hope for is an adequate awareness of the various principles that have influenced the research process. This awareness has its limitations, as the very language that one uses to think, explore, and write brings with it specific and often covert assumptions of what it means to engage in these processes. Thus it is important that the researcher remains mindful of the various influences that facilitate and impact on the research process. I do not think that Fromm's (1980) contradiction can be resolved by doing away with the elements that constitute the spirit of the researcher's context. Rather, I have attempted to remain aware of the elements that have constituted and undoubtedly influenced the research

process, including: a particular theoretical framing of how psychosis develops and how it is managed; specific and differing treatment contexts; my own ideological views on how psychotic patients should be treated; my reactions to differing views on the management of psychosis; supervisory input received from various sources; as well as my own motivations for conducting this research.

The extremely subjective nature of the phenomena researched in this thesis implies that the quality of the research relies primarily on the depth of exploration rather than on the generalizability of the findings (Coar & Sim, 2009; Varvin, 2011). Generalizability does nonetheless remain important as one of my aims was to contribute to the existing research on psychoanalytic psychotherapists' experiences of working with psychosis. In order to enhance the quality of the research in this regard I relied on the existing literature, both in terms of theoretical models and experiential accounts, and on a thorough investigation of the specific phenomena that I have focussed on to ensure that the findings can be appropriately situated alongside the established corpus of knowledge. This included rigorous engagement with concepts like 'countertransference', 'the development and treatments of 'psychosis', 'delusions', 'subjectivity', as well as the various 'psychological and psychiatric ideologies' that structure the context within which I have conducted this research. The engagement with these concepts included interrogating the different and at times contradictory definitions of these terms, and clearly representing the resulting tensions between the different positions. Defining the development, nature, and treatment of psychosis has also been done in a manner that represents the variance in views found in the literature, as well as my own views and how these views have influenced my approach to the research. Being clear about my own views on the treatment of psychosis and situating them in relation to the established literature was important. These views held the potential to dictate how I interpreted the data, and in turn would influence the quality, validity, and authenticity of the research (Fossey et al., 2002; Sarantakos, 1998). In accordance with this, my aim was to remain mindful of the possible effects that external and personal factors could have had on the interpretation of the responses. This included my own personal belief that it is not only possible, but important to include psychotherapy in the treatment of patients suffering from psychosis. I took care to manage this belief in a manner that did not negatively influence how I developed the interview questionnaire, conducted the interviews, analysed the data, and interpreted the material. As I am familiar with this area of study and hold particular theoretical views while rejecting others, I attempted to remain open to alternative views in order to avoid conceptual blindness during

the process of data analysis (Coar & Sim, 2009). This was crucial in ensuring that the acquisition of novel insights remained possible, as the focus of the study – psychotherapists' experiences of working with psychosis – explored accounts that were highly subjective (Coar & Sim, 2009). Researching countertransference phenomena based on experiential accounts was, and should be, a delicate task guided by a strict adherence to clear definitions of the terms used, and an honest and clear account of the experiences of the participants as reported by them. To further promote internal validity, the research supervisor acted as a second analytic assessor by virtue of contributing to independent analysis of the data (Elliott, Fischer, & Rennie, 1999). The PhD cohort which consisted of other PhD students and senior members of staff of the University of the Witwatersrand also contributed to promoting internal validity via in-depth involvement in each stage of the research process.

The external validity of this process was promoted by comparing the results to similar studies such as that of Conolly & Cain (2010), and by comparing the results to existing psychoanalytic literature on therapists' accounts of formulating and working with severe psychopathology, as there is very little literature on therapists' experiences of engaging with psychosis to use as a check (Bryman, 2004). Specific to the particular Ph.D. program that has facilitated this research process was the requirement that each of the four articles is accepted for publication in an established peer-reviewed journal. This requirement has been met. With each paper, engaging with the feedback provided by the reviewing process has made a considerable contribution to the external validity of the research.

Ethical considerations

In order to promote the expansion of knowledge of what is understood about psychotic patients and how therapists experience engaging therapeutically with this patient group, the study endeavoured to render public the very private and intimate encounters that these experiences are based on (Willig & Stainton-Rogges, 2008). This is the nature of qualitative research (Mouton, 2001). Thus I needed to conform to certain key ethical guidelines in order to promote the balance between obtaining information, and protecting its source (Mouton, 2001; Willig & Stainton-Rogges, 2008).

Interviews

Informed Consent

Firstly I obtained ethical clearance from the Human Research Ethics Committee (HREC – non-medical) of the University of the Witwatersrand before commencing with data collection. Participants were recruited as described in the methods section. Care was taken to phrase the letter to invite participation (Appendix B) in a manner that was clear and comprehensive, that invited participation freely, stated all possible risks and benefits understandably and remined prospective participants that they are free to withdraw from the study at any point without any foreseen negative consequences to themselves. The primary function of the information sheet was to enable participants to make their decision to participate in the research, or not, based on a comprehensive understanding of what the process would entail and what the purpose of the research is (Homan, 1991). Participants obtained a signed copy of the consent form ensuring the confidentiality of the material. The informed consent form also contained the contact details of the writer in case participants had any questions or concerns.

Confidentiality

In light of the possibility that some of the research participants could potentially identify themselves via the vignettes used in paper 2 and paper 3, care was taken to omit information that could be used to identify any of the research participants beyond the stated facts that they are all psychologists, working in Johannesburg, and practicing within a psychoanalytic framework. While the psychotic patients that were discussed during interviews represent a vulnerable population, these patients were not affected directly by the interview process. Maintaining the confidentiality of patients that were discussed in interviews, as well the integrity of the material and the therapeutic process, whether current or past, were also important considerations. Participants were made aware of this, and were encouraged to omit identifying information when referencing case material, as confidentially as core ethical component of any counselling process extends to the process of research (Patterson, 1999). I also took care to exclude any identifying information of patients in the final report, and treated the case material provided by the participants with the utmost sensitivity and respect. The interviewee research population were not considered a 'sensitive group', in that they represent professionally trained adults who volunteered to participate in the study.

Since there are clearly many different and opposing schools of thought with respect to the treatment of psychosis, I was careful not to put participants into a difficult position by making

them feel that they should advocate a specific approach to treatment. To further hold in mind the sensitivity of interviews I took care not to place the participants in an exam-like situation in which they felt like their knowledge was being tested (Coar & Sim, 2009). It was stated clearly that no preparation would be necessary prior to the interview. These considerations contributed to allowing the participants to maintain their professional identity, while encouraging them to share primarily subjective experiences of engaging in this kind of work (Coar & Sim, 2009).

Interviews were digitally recorded. The recorded and transcribed material has been stored in password-protected files. Only myself and my research supervisor have access to this data. Confidentiality was maintained through the use of pseudonyms, and no personal information that could lead to the identification of participants was included in the research report. Some direct quotations were included in the report to substantiate an argument, or highlight a point, and interviewees have been informed of this. Although this implies the verbatim account of the interviewee's responses, all personal information that could lead to identification have been omitted or altered. Since I am aware of the participants' personal information, anonymity cannot be preserved.

There were no foreseeable situations during the research process that could constitute a conflict of interests.

Case Study Material

The importance of confidentiality as core ethic in relation to the therapeutic process also extends to the process of using case material for research (Patterson, 1999). The case study material was based on personal observations, therapy notes, supervision notes, and memory transcripts. Written permission to use the case study material used in the first standalone paper had been obtained from the Clinical Head of Chris Hani Baragwanath Hospital in Johannesburg, as well as from the patient. The process of obtaining consent from the patient was not taken lightly. This process involved in-depth consideration of: whether, at the time at which consent was obtained, the patient was able to grasp the implications of what it meant to give consent to being included in a research study; whether and how the act of approaching the patient to be used in a research study could have any negative effects on the patient; and whether the patient's participation in the study could have any retrospective effects on the completed therapy that stand to damage the relationship or the therapeutic work done. The use

of the material had no foreseen negative implications on the therapeutic relationship, as the therapy was terminated in 2010. Confidentiality was maintained throughout by using a pseudonym, and by omitting or disguising any identifying information. The material was used in a manner that is respectful of and sensitive to the patient's therapeutic process, as well as the context in which the therapy took place.

The case material used for the fourth standalone paper informed the creation of a composite narrative. The focus of this paper was on the psychotherapist's experiences of being implicated in the paranoid delusion of a psychotic patient. This approach was opted for as this is a very vulnerable patient group, hence the notion of consent and its ethical implications needed to be considered very carefully (Alfonso, 2002; Aron, 2016; Gabbard, 2000; Gabbard & Lester, 1995). Obtaining consent from these psychotic patients, as well as from the patients who I am not currently treating stands to be counterproductive to the therapeutic aims of their treatment, and potentially damaging to the therapeutic relationships (Aron, 2016). A composite case study combines aspects of a number of cases in such a manner that the resultant case contains material that would not be recognizable to patients themselves and would not allow any third party or other readers to recognize them (Alfonso, 2002; Willis, 2018). Thus, the use of a composite narrative prevents any breaches of patient confidentiality (Willis, 2018). Additional ethical clearance to use a composite case was obtained from the Human Research Ethics committee of the University of the Witwatersrand, South Africa.

Published Papers

The four published papers are presented in the original format in which they were published.

Paper 1: Flying Blind in the Psychotic Storm

Introduction

This section captures my own introduction to and grappling with working with psychotic patients. The journal article that makes up this section is based on my experiences as an intern clinical psychologist working in an involuntary male psychiatric ward in a government hospital in South Africa during 2011. The article explores a relatively long-term twice-a-week therapy

with a psychotic patient. In many ways the writing of this article provided me with a space where I could begin to cohere and engage with my own uncertainties, concerns, interests, and curiosities around working therapeutically with psychotic patients. This process is far from finished.

Paper

ABSTRACT

Therapeutic interventions in psychotic patients remains for many both a controversial and confusing area of clinical work. This paper aims to explore the therapist's experience of countertransference when working with psychosis. More specifically, how the therapist's experience of both the patient's and their own psychotic parts leads to a disturbance and a momentary fragmentation of the therapist's self-reflective capacity, and how this stands to influence the therapeutic process. Although there exists a vast body of psychodynamic literature on the nature and development of the psychoses, there are very few experience-near accounts of the therapist's countertransference. In this paper I attempted to represent something of my own experiences of countertransference when working with a psychotic man in twice-a-week therapy over four months, and on how it affected my interventions, doing so through the use of case material included in the paper. I drew heavily on the fundamental psychodynamic theorists to help elucidate my experiences, and supplemented them with more contemporary views on the nature of this illness. The case material is followed by a focus on key themes chosen to represent the intersection of the patient's madness and my own as understood via my countertransference. These themes include; the use of language in psychosis, psychotic transference and the therapeutic relationship, dreaming as talking, and adding value: the therapist's need. I conclude the paper by arguing that working with psychotic patients via one's countertransference opens the therapist up to self-reflective failure, and that these disturbances represent an important part of the work.

INTRODUCTION

Working therapeutically with psychotic patients is arguably one of the most indeterminate and confusing areas in the field of psychoanalytic psychotherapy (Bion, 1957; de Masi, 2009; Joannidis, 2013; Schwartz & Summers, 2009; van Bark, Wolberg, Eckardt, & Weiss et al., 1957). It is an area characterized by debates around whether one can or should intervene therapeutically with psychotic patients (Bion, 1957; Freud, 1924a/b; Kingdon, 2004; McGorry, 2002; Steinman, 2009). It is also a field where the treatment of choice appears to be the use of antipsychotic medications, rather than psychotherapy, as there are many who view therapeutic interaction with psychotic patients as counterproductive (Lehman & Steinwachs, 1998; Lucas, 2003; Saayman, 2011; Steinman, 2009). Despite the predominance of this view, there exists a large body of in-depth psychoanalytic literature that focuses on understanding psychosis, how it develops, what it is that psychotic patients need, and different methods of therapeutic intervention. Recently, there appears to be growing acceptance of the legitimacy of psychoanalytic approaches to working with psychotic patients, to the extent, for example, that Jackson (2008) advocates increased use of this approach in the British NHS and Summers (2015) reports on work towards a randomized controlled trial of psychodynamic therapy for psychosis.

What has received considerably less attention is the experience of therapists who work therapeutically with psychotic patients (Cain, 2010). There are very few experience-near accounts of therapists' countertransference when working with psychosis, or how these experiences specifically affect the therapeutic process. There is recognition that this work is particularly taxing on the therapist, in part because it requires the therapist to enter into a terrifying and confusing place with their patients, and in part because the therapist's often disturbing countertransference is an unavoidably important part of the therapeutic process (Arieti, 1957; Bio, 1954; Cain, 2010; Garfield & Dorman, 2009; Kernberg, 1968; Klein, 1946; London, 1983; Schwartz & Summers, 2009). Given the recognition of the particular challenges inherent in this kind of work, an exploration from the therapist's perspective on how these experiences influence the therapeutic process seems particularly valuable.

Interestingly, there is a large body of literature on therapists' experiences of engaging with a wide variety of psychological disturbances (e.g. Buechler, 1998; Coburn, 1998; Davies, 1999; Hepburn, 1992; Hoffman, 1983; Horlick, 2006; Lewis, 1991; Lijtmaer, 2010; Schachter, 1990; Shapiro, 2009; Skolnikoff, 1993; Spillius, 1992; Stern, 1989; Teitelbaum, 2003; Wilner, 1998; Wilner, 2006; Zuckerman & Sinsheimer, 2007) but very little literature highlighting the therapist's experience in relation to psychosis and countertransference, and the therapeutic importance illustrated through case material. A primary aim of the paper, then, is to present a case study of a therapist working with a psychotic patient, and to develop a very particular kind of experience of countertransference in relation to psychosis. In order to tease out the therapist's experience and how it potentially affects the therapeutic process, the paper goes on to examine an inherently confusing dynamic in this kind of therapy. The therapist is, at times, required to access a psychotic part of his own psyche via his own countertransference in order to reach the patient. (Arieti, 1957; Benedetti, 1999; Bion, 1954; Kernberg, 2003; Hopkins; 1992). In order to reach the patient, the therapist needs to navigate both madness and sanity, within himself and his patient, at times in a manner that can lead to a breakdown in the therapist's meaning-making capacity as a result of a countertransferential link to their own madness (Arieti, 1957; Benedetti, 1999; Bion, 1954; Kernberg, 2003; Hopkins; 1992).

It may indeed be this very dynamic that so often results in therapeutic engagement with psychosis being avoided or discouraged: therapists feel they are at risk of experiencing both their patient's psychosis and their own when they open themselves to this type of work.

Bollas (1983), in a paper on the use of countertransference, speaks to this risk in a startling manner when he describes the therapist's experience of degrees of madness – an experience that he sees as necessary. Considering the importance of this confrontation, Bollas (1983) asserted that the therapist has to approach madness within themselves in the manner in which they would the patient's illness, as this is what promotes the patient's health. Searles (1951; 1963; 1966; 1967a; 1967b; 1968; 1970; 1971; 1972; 1973; 1975), based on many years of working with psychotic patients, wrote extensively on therapists' countertransference when

engaging with psychosis. Reflecting on the therapist in this position. Searles (1967a) stated that the therapist will in no other situation be faced with so brutal a confrontation with their most primitive anxieties, and fears of disintegration. Kernberg (1986) spoke of a disturbing experience with a psychotic patient during which he struggled to differentiate between himself and his patient. These examples point to a moment during the therapeutic encounter where the therapist suffers a temporary arrest or breakdown of their organizing principles. Specifically, a countertransferential *disruption* of what Ogden (1994; 1997) referred to as self-reflective thought – the ability of the "I" (subject) to observe the actions and experiences of the "me" (object). In this paper I align myself with the view that the disorientating encounter of psychosis cannot always be made sense of in a coherent and understandable way, and that, at times, the therapist's countertransferential response to the patient severely compromises their sense-making capacity (Arieti, 1957; Benedetti, 1999; Bion, 1954; Grotstein, 1994; Hopkins; 1992; Kernberg, 2003). Often the most that the therapist can hope for is what Ganzarian (1997) refers to as a confused non-conceptual understanding, where self-reflective function begins to falter and disappear, if only momentarily. For me this disturbance does not necessarily imply a complete break with reality, but rather a slipping of self-reflective function, (Benedetti, Furlan & Peciccia, 1993).

When the therapist's self-reflective function remains intact during an encounter with their own psychosis, they are able to account for their experience, and to relate it to the therapeutic moment, as well as to the patient. The work of Searles (1951; 1963; 1966; 1967a; 1967b; 1968; 1970; 1971; 1972; 1973; 1975) illustrates the results when the therapist's self-reflective capacity remains intact when working with psychosis. In providing accounts of his therapeutic encounters Searles demonstrated the ability to use his self-reflective functioning *whilst* making sense of his countertransference. One such example depicts his experience of intense suicidal ideation as a result of being transferentially cast as his patient's long-depressed father (Searles, 1963). Searles (1963) located both himself and his patient in relation to, but apart from his own madness and its effect on his organizing principles, here his countertransferential experience of psychosis did not appear to compromise his self-reflective function.

Winnicott provided another striking example of engaging a patient's madness, doing so from what he understood to be a mad space or process within himself (1949). Winnicott (1949) saw and described his adult male patient as a little girl, whilst in the moment reflecting on both the absurdity of the notion, as well as the realness of his experience. Both neurotic and the psychotic are held, and the patient confirmed this by stating that Winnicott (1949) spoke to both parts of him. As in the example of Searles (1963) the experience of madness was rendered and represented as understandable. Winnicott's extraordinary allowance for his countertransference and the madness it evoked occurred under the supervision of his self-reflective capacity I view these examples of therapists engaging their patients' madness via their own countertransference as profound. The ability to hold onto one's own mind whilst allowing for an experience of something psychotic located both within and without oneself is an extraordinarily difficult task.

In order to explore this countertansferential disturbance, after the case is presented, the paper will discuss four aspects of the case-study that illuminate the idea of a breakdown in the therapist's self-reflective function. Two of the hallmark aspects of work with psychosis that so often surface are explored in terms of how they both compromise and advance reality. These include the use of language in psychotherapy with a psychotic person, psychotic transference and the therapeutic relationship. The third aspect borrows from Ogden (2007) the concept of dreaming in order to suggest that one – paradoxical – way out of the therapist's blurred dilemma is to understand that the therapeutic engagement is a kind of 'dreaming as talking'. The paper concludes with a pulling together of the mentioned themes to illustrate the experience of a very specific element of working with psychotic patients – a countertransferential encounter of madness that momentarily undoes the therapist's organizing principles, and arrests self-reflective function.

Working with psychosis: The case of Dale

I present the following case as an illustration of working with madness, and of how my countertransferential responses affected my own self-reflective functioning. Six sessions have been chosen to illustrate a therapy that took place over a four-and-a-half month period, twice a week, with a schizophrenic patient in one of South Africa's public hospitals.

It should be noted that the setting of this psychotherapy, in a public inpatient facility, offers a particular context and sometimes particular challenges for this work. In describing the case study below, the flavour of this context has been retained and may offer readers insight into work in public health settings. The paper does not, however, directly explore the implications of work in this setting, opting instead to maintain focus on the therapist and patient. In so doing, I hope to convey that, regardless of setting and likely across different settings, this focus is illuminative of the therapist's experiences of work with psychosis.

The patient is a black male whom I will call Dale. He was twenty-seven years old at the time of the therapy, and was a long-term patient in a male psychiatric ward in a Johannesburg public hospital. He was diagnosed with a psychotic disorder three years prior to our first meeting, and had been admitted to the same male psychiatric ward for the fourth time when his therapy with me began.

1st session

I introduced myself to Dale, and explained that I was a psychologist. He was unsure of the pronunciation of my name (Nardus), and repeatedly called me "Dr Wonderers". He proceeded to tell me about his camera, explaining that he enjoyed taking pictures. When asked what he liked taking pictures of, his "mansion" was the answer. He stated that the mansion was not built, but that he had drawn up plans for the building. He went on to explain that he needed to climb a mountain, Mount Kilimanjaro in particular, and asked whether I thought that we could do it. I said that I was wondering whether climbing a mountain seemed like a big task to him, and he confirmed that it did, and that we might need a third party to help us. I asked what type of individual he had in mind, and he explained that it had to be someone strong and trustworthy. I questioned whether it was difficult to find people whom one can trust, and he stated that it was. When asked whether he had anyone particular in mind he said "Thabo" (pseudonym), a friend of his from school. When I said that we needed to end the session, he thanked me for my intellect, and said that he wanted to pay me. I asked him how he wanted to pay me, and he stated that he would work hard to climb the mountain, after which I reflected that he seemed to feel good about our session. At this point he became quite excited. He shook my hand vigorously,

and turned around to walk back to his room.

2nd session

I went to the ward in the morning at 8:30, at our agreed-upon time, and found Dale in bed, still asleep. A fellow patient awakened him, and I asked him whether he would prefer for me to come back later, which he said he would. I saw Dale that afternoon at 14:00, and asked whether he remembered who I was. He confirmed that I was Dr. Wonderers, the psychologist. As we walked into the room he asked me whether he could "break" the mood with the following joke: "There was a wise old man living on top of a mountain. One day a young boy decided to climb the mountain to find the old man. As he got to the top he found him, and asked "are you the wise old man?" To which the old man replied (in a thunderous voice), "young man I will throw you off this mountain!" Dale looked at me with some anticipation. We sat down and I asked him whether he didn't think the old man sounded a bit scary, to which he shook his head in disagreement. He went on to tell me that he needed to study first, that he needed to pass his Matric before we could climb the mountain. I asked him why he had failed his Matric, and he said that he had become involved with drugs and alcohol, and that it was a shame as he was a very promising student. He repeated that he needed to study before we started therapy, and I reflected that perhaps climbing a mountain seemed like an intimidating thing to do. He agreed, and asked me what we would do if we found a dead body on top of the mountain? I asked him what he would do, and he said that he was not sure. Dale then enquired whether I had ever done anything significant with my body. I asked what he meant, and he said "like mountain climbing". I stated that I used to do rock climbing, at which point he became noticeably excited. I asked him why this was important, and he explained that very few people do something significant with their bodies, but that it was important for him to know about the people he fell in love with. As I told Dale that we needed to end the session, I added that I thought it would be good if we saw each other more than once a week. I asked what he thought, and he agreed. We decided to see each other every Monday and Friday.

13th session

I arrived at the ward, and found Dale standing in the hallway, looking his more usual vibrant self. He came into the room and walked right up to me sniffing loudly. He

turned and sat opposite me. I did not comment on the sniffing. The room was large and cold, and upon his return I asked him whether he was warm enough, and he said yes. He spoke with an American accent, and started telling me that his father organized a role for him in a film in New York. He explained that he needed to have his accent ready, and that he wondered whether I would help him with the screenplay since I inspired him. He spoke of his audience, and I asked him what the function of the audience was, why they were there. He stated that they were there to wait for him, and we discussed how difficult it could be to wait. I asked him whether he had waited long for me the previous week, and he said that he had. I mentioned that, perhaps he had been waiting very long, until the end of the week, and that maybe it felt like I made him wait. I also said that he might have been tired of waiting, and hungry for the session, with which he agreed. He went on to tell me that he needed help with the right mental frame of mind, as he was compliant last year. I asked him what he meant, and he explained that he took Clozapine for his mental wellbeing. I enquired about his experience in the ward, and he responded by telling me about his six ex-girlfriends who committed suicide because he did not stay with them. I asked him what he meant when he said that I inspired him, and he explained that I just did, that he looked forward to seeing me. At that point we were made aware that someone else needed the room, and we ended the session. As we walked out, Dale asked me whether he could close the door to tell me something, and I said that he could. As we went back inside he made it clear that he wanted to pray for me, and immediately sat down and prayed the Our Father. Afterwards I said that he seemed to want me to be safe and well, and he said that he did. I thanked him for this, and he shook my hand energetically, after which he walked out of the room. As Dale left, I realized that I was experiencing a slightly altered state of consciousness, not a state as extreme as a dissociation, but a strange sense of ‘unreal-ness’. I found a colleague in the corridor, and asked her whether we could speak. I explained my experience, and at once felt like I was speaking too loud. I asked her whether I was, and felt like laughing while doing so. Amidst this I also became aware of a sense of fear, mixed with a boundary-less wish to merge with others. I walked back to my office, trying to notice my surroundings. After a minute of walking I could scarcely recall the sensation I had just experienced.

18th session

I was on leave for a week and missed two sessions. Dale kept a diary of his thoughts on those two days, and presented them to me when I returned. I asked Dale to read them to me. Dale used his writing to explain that he spoke to his sister over the phone, and that she told him that his cousin had burned many of his illustrations. I asked him how he felt about this, and he remarked that it was fine, as his formulas remained intact. When asked how or why the arson occurred, Dale stated that his cousin was punishing him for not being around, as he used to play an active role in his life while living at home. The discussion led to talking about relationships in general, and I asked him the name of a man he had mentioned in previous sessions, who he had dated in 2007 after meeting in a bar. He immediately began to speak in an American accent, and reflected on people having different strengths. I asked him what his strengths were. He answered me without the accent and spoke about adding value. Dale explained that it was important to add value to people's lives. I asked him which people added value to his life. He thought about this for a moment, and then replied that his mother and sister added value to his life, as did his friends. He then seemed to veer off, speaking about and distinguishing between heavy current and light current objects. He did not clarify the distinction, but said that he was let down by these objects, which made it difficult to trust them enough to be real. I asked him what being real meant, and he said that it was a state where no mind-altering substances were present. He explained that this was the state in which he could paint and draw. I asked him whether he felt like he was really himself when he was not using any mind-altering substances, and he agreed. I asked whether this included his anti-psychotic medication, and he replied that it did.

22nd session

Dale began the session by saying that he was his mother's favorite. I asked him what he meant, and, although reluctant to tell me at first, he explained that he had made fifty thousand rand in two weeks selling textiles. He emphasized that "he added value", a phrase he often used, and that he had paid off his father's car. We explored the concept of adding value, as we had done before, and Dale related how both his brother and sister did not add value in the manner that he did. These were the main themes of the session. As I stated that we needed to end, Dale said that he wanted to ask me something, and I agreed to this. He seemed slightly nervous, and

proceeded to ask whether I would like to have a career first and a family later, or a family whilst having a career. I asked him why he wanted to know, and he replied that I was answering his question with a question, calling me “Dr. Nardus”. I explained that I was willing to answer his question (which, essentially, I never did) but that I was wondering why he wanted to know. He then said that it was important to be appreciative of family members, and I asked him whether he was really appreciated by his family, to which he replied “no”. He then asked me whether we could be friends, and I reflected that perhaps he was wondering whether our relationship could be more than just a professional relationship, but that it may be risky to ask, to be vulnerable, and to risk not being appreciated. Dale agreed with this, and seemed content with my answer.

25th session

We had to conduct our session in the dining room, as space in the ward was scarce. I explained that this was the case, and Dale appeared to be fine with this. He seemed happy to see me, and began the session by asking me how I was. I replied saying that I was fine, and asked Dale how his visit home the previous weekend went. He proceeded to tell me that he had the attention of many women who wanted to talk to him, and that he had trouble getting some time alone. Much of this session revolved around Dale placing himself in a positive light. With the same inflection with which he told me about spending time with his friends he explained that his grandmother had passed away on the Saturday morning. I said that I was sorry to hear that, and that it must have been difficult news to receive. Dale seemed to respond to this, objectively seeming more in touch with his sadness. I asked whether they were close, and he stated that they had only ever met twice. He did not elaborate on why, and I wondered whether this was really the case. As is customary in his culture a bull was slaughtered for the funeral, and he asked his father whether he could help. His father refused. I asked him why, and Dale explained that someone had probably refused his father when he was young, and that this was why he was taking it out on him. When asked whether others taking things out on him was something that he had experienced before, he stated that he had. He then went on to say that his family members bottled things up, and that it all ends up exploding. I asked whether he ever bottled things up, and he said that he had me to talk to, which kept him from bottling things up. He then went on to explain how the bull was

slaughtered, stating that he would like to know how to cut it up properly, and to be able to distinguish between fillet, thigh, T-bone, and ribs.

DISCUSSION

In offering a reflective analysis of the therapy, the aim is to provide an account of a therapeutic intervention with a psychotic patient, and to illustrate some of the countertransference experiences that this process evoked within myself - in particular the effects on my capacity to organize my experiences, and particularly on my reflective function (Ogden, 1994). The first three themes to be discussed below, addressing the use of language, psychotic transference and the therapeutic relationship, and the concept of dreaming as talking, highlight the experience of the blurring of sanity and madness. The fourth section reflects on how my experience of working with psychosis, whilst having at times undone my self-reflective capacity, also proved deeply rewarding and restorative – an experience that also formed part of my countertransference, and one which I needed in order to sustain the work.

The use of language in psychosis

The use of language in psychosis reflects an issue that sits at the core of the psychotic patient's aim of destruction of psychic reality (Bion, 1957). Bion (1957) explained that the capacity for verbal integration of reality implies an ability to acknowledge the parts of reality symbolized by language, as well as the capacity to link these occurrences to the emotional experiences which they produce. This capacity is indicative of the depressive position, and one of the hallmark features of neurotic-level functioning, a level of integration that a psychotic individual rarely possesses (Klein, 1946). Dale's use of language was often characterized by the strangeness of psychosis, but it would be incorrect to categorize all of his communication as an attack on reality. On the contrary, what often made it so confusing to follow Dale was that his talk was simultaneously concretely bizarre and yet far from devoid of meaning. His use of language suggested something important about his engagement with reality and also threw light on my often-unconfirmed attempts to understand him.

Dale's sustained use of the trope of mountain climbing is an interesting example. Mountain climbing was, for Dale, a concrete reality standing in place of external

reality. Mountain climbing was a symbolic metaphor experienced as an actuality. This 'concrete' use of symbolism can distance one from what language represents, particularly when what is represented is distressing or threatening (Leader, 2012). Symbolic representation, and its function to disguise typically operate in dreams, in the realm of the unconscious (Freud, 1900). The psychotic individual often communicates directly via the unconscious, and if we take Dale's communication as such, an interpretive stance akin to dream interpretation serves well to elucidate meaning (Freud, 1900; Leader, 2012). Holding the possibility of determinable meanings and identifiable symbolically disguised wishes and fears, does, however, keep the therapist in the realm of speech understood as communication, fulfilling only part of what the psychotic patient invites one to engage with. Analyzing language-use in severe pathology should aim to hold the consideration that, in severe pathology, talking can imply *doing* for the patient – we *are* climbing the mountain by talking about it (Calamandrei, 2009). The challenge for the therapist is to simultaneously listen to psychotic communication whilst holding the various different functions of the communication, functions that represent unconscious material (Stern, 1989). Dale's use of language frequently left me with a strange mix of amusement, confusion, interest, and unease. The question "what is he saying, or trying to say?" would often permeate my thought process, and would unfold into "is he saying, or is he doing, am I listening or watching or participating in the doing?" spiking my anxiety. When Dale told the joke about the old man in session 2 I thought about the possibility of it being a transferential communication, and that I might be the shouting sage. But I could not say this, what if the idea of me as me, as well as me as someone else overwhelmed him? I also wondered about the joke not being a symbolic representation, but an actual experience for Dale, his experience of therapy. I could not decide how to respond, or where I fitted in, and simply asked whether the old man was scary. He sounded scary to me, and that was about the only thing that I was certain of in that moment. To be certain, it was I who was afraid, I had no idea what was going on.

The attempts to avoid my own countertransference were frequent. The experience of struggling to understand evoked a defensively motivated pressure to understand – "if I did not understand him, I was not doing therapy". This pressure to understand was, however, my attempt to hold onto my self-reflective functioning - my attempt to focus

on the anxiety in my awareness, rather than the much more primitive unacknowledged anxiety that was not a result of not understanding, but the result of my countertransference. This *not keeping it (me) together* was much more terrifying than *not getting it (him),* an experience formulated by Searles (1971) when he reflected on the therapist's self-reflective capacity failing as a result of contact with the psychotic patient's inability to organize their own experience. My conscious attempt at meaning making may very well have been a defensive reaction to my countertransference – an unwillingness to allow for the very space that would serve as justification for my interpretations, a space touching on my own madness (Bion, 1954; Stern, 1989; Winnicott, 1949). I found it very difficult to remain with Dale in spaces of multiple doings and thinkings and sayings, often moving away from his accented speech or ideas of adding value, moving away by not understanding. If I could view his communication as crazy, him as the mad one, I get to hold on to me as the sane one (Paola, 2000). Yet only in meeting him through my countertransference, could I really meet him where he was at (Bion, 1954; Kernberg, 2003).

Psychotic transference and the therapeutic relationship

Reflecting on my work with Dale, it feels clear to me that the relationship between us was core to the therapeutic work. It provided different functions, both for Dale and for myself. In part a function which I needed, was that of a broad boundary of sorts, a place that still existed when my countertransference warped my experiences (Benedetti, 1999; Rosenfeld, 1969). Dale made frequent direct and indirect references to our relationship, whether via the idea of climbing a mountain *together*, in the second session expressing the importance of coming to know the person whom he fell in love with, or his reference to diary-keeping, the therapeutic relationship was represented as both a very real entity and as an idea evoked through psychotic imagery. Dale's reference to falling in love, if taken as an unconscious derivative communication, indicated that for him too something of our relating was significant (Langs, 1984). However, the act of negotiating this relationship often defied the boundaries of conventional relating, going beyond the notion of multiple meanings and realities, and straying into differing meaning-making principles altogether (Searles, 1967a). There is something quite unnerving about an interchange with a psychotic patient where the therapist is allowed to assume far

less than when working with a saner individual. A psychoanalytic way of working implies the therapist's intention to suspend assumption, yet much has to be assumed to make relating possible. One such 'common' assumption is that the words we use hold the possibility of multiple meanings selected from a more-or-less normative pool - a phenomenon reflected on in the previous section (Bion, 1957). Working with Dale, holding onto assumptions rather than possibilities would serve only to defend against his psychotic process and what it stands to evoke in me, and so for me our relationship became an incredibly important aspect of the therapy in the sense that it served as the only constant and real shared *thing* between and around us (Benedetti, 1999). In my mind it became the space *within* which all the madness could happen, both his and my own (Benedetti, 1999). This afforded me license to reinvent my analytic stance in relation to his psychotic material *within* an aspect of our therapy - the relationship - that held both him and myself (Benedetti, 1999; Ogden, 2007). Granted the concept of our relationship as I formulated it both then and now is held and experienced thus by me, and not necessarily by Dale. It is a reflection on my experience of the relationship, and how Dale seemed to respond to it. It is a reflection on the fact that the madness needed to be located somewhere during the brief spaces where my countertransference left me utterly confused and bereft of self-reflective function (Kernberg, 1986).

The psychotic patient's frequent failure to adequately navigate interpersonal boundaries can also make for challenging work, as was the case when Dale would sidle up to me and smell me, trying to guess the brand of my aftershave. I found this very unsettling, as I was caught off guard, disinclined to respond with a sensible comment around his wish to be close to me. McWilliams (1994) explained that one of the principle conflicts of individuals on the schizoid spectrum concerns distance and closeness, love and fear, a wish to be known and a wish to retreat, and that a deep ambivalence about attachment dominates their internal world. Throughout the therapy, as was indicated in session 2, Dale seemed to try to negotiate the boundary between himself and me, perhaps attempting to establish and make sense of who I was, and what he felt in relation to me. What made these attempts so disturbing was that I frequently felt that Dale, rather than presenting me with a part or experience or wish of his to be thought about, was literally trying to get inside of me, to be thought about and felt, or to share his own experiences of intrusion or engulfment by

inserting himself into me (Bion, 1954; Kernberg 1968; Searles, 1971).

The willingness to take on the psychotic patient's communications implies opening oneself up to very powerful and potentially frightening projections, projections that actively search for corresponding madness within the therapist (Bion, 1954; Bion, 1957; Hill, 1955; Kernberg 1968; Searles, 1971). I experienced something of the potential strength of these projections when Dale prayed for me in session 13. As he recited the Our Father my thinking revolved around the possibility of Dale caring for me, and of him needing to express this somehow. I felt calm, and comfortable with the idea of him praying for me. Only after Dale had finished and left the room was I left with an experience of an altered sense of reality, coupled with an awareness of intense fear. I felt that Dale had left something in me via a symbiotic interchange (Searles, 1971). This was not just a matter of Dale leaving something psychotic in me, what he left in me had found a corresponding place to reside, the psychosis was transferred to *something that was like it*. This thing or place in me may have been what Bion (1978) made reference to when he explained that we all have a psychotic core situated inside of us that can be affected by the psychosis of another human being, or be evoked by psychotic projections. If we agree that psychotic projections are fragmented, we imply that the parts that the therapist has to hold are simultaneously perplexing and contradictory, and unbounded in a particular time and space - again much like dream material (Bentall, 2003; Bion; 1978; Hill, 1955; Freud, 1900). I felt Dale's psychotic projections infect the meaning making mechanism I employed to make sense of him, I was lost to my countertransference. In that instance, all we *really* had was our relationship. This meant that the exchange between us could happen, and that he could communicate what he had to. What he had left me with, however, was profoundly disturbing. I felt my self-reflective functioning begin to slip as I sensed a seductive urge to laugh, and the intense corresponding fear at the realization that the urge was not mine. There were no meaning-making *whys*, only terrifying countertransferential *whats*. Our relationship facilitated both his holding, and decline.

Dreaming as talking

In his paper On Talking as Dreaming, Ogden (2007) addresses an ideal, that of the therapist and patient being able to dream together, much in the same way in which,

ideally, the child therapist and patient aim to play together in the Winnocottian sense. This ideal denotes an exchange between therapist and patient where the patient uses creative means to dream themselves into being (Ogden, 2007). Patients use imaginative works like books, art, or films to represent their unconscious material, or a bearable aspect thereof. Ogden (2007) was speaking here of neurotically structured patients, and of how they make use of the external world to facilitate the representation of their unconscious material. But what does talking as dreaming look like for the patient who is psychotic? One needs dreaming to deal with dreams, as one needs thinking to deal with thoughts, and both dreaming and thinking converge as our experiences are represented on multiple levels (Ogden, 2007; Bion, 1957).

Freud (1900) made the point that, in order to listen to the unconscious we need to understand how dreams are structured, and what they represent of our unconscious material. When we listen to the neurotic patient's dream, we listen *for* their unconscious. Here operates a consolidated structure with demarcated entrances and exits, regulating the exchanges between conscious and unconscious (Freud, 1900). So, for the neurotic, talking as dreaming implies accessing an unconscious part of the self, and doing so willingly via creative aids. Leader (2012) made the veracious observation that psychotic patients communicate through Freudian slips. For a neurotic patient, a Freudian slip often proves embarrassing, as a part of the self is involuntarily revealed. Something happens which acts against the patient's conscious wishes, something happens unwillingly. The psychotic patient, however, does not experience their unconscious as an interruption of their conscious experience, but rather as the facilitator of their experience (Leader, 2012). Thus the psychotic patient dreams while awake, navigating a conscious world inhabited by unconscious material, *dreaming as if talking*. In other words, the psychotic patient's difficulty in distinguishing between what is real and what is not, manifests as an active *un-awareness*, an attack on awareness, of the fact that they are in a sense dreaming while awake.

As therapists we cannot wake the patient from this kind of 'state', an idea that can leave one feeling helpless when confronted with patients living nightmares rather than dreams. These patients dream themselves into existence, and being woken by reality may very well be experienced as an annihilation of the self (Ogden, 2007).

Meeting the patient in the dream via one's countertransference, I have found, can be equally disturbing for the therapist. For me the concept of *talking as dreaming* serves a helpful function here, a type of mediation between the respective unconscious spaces of the therapist and patient. Freud (1900) described the powerful ability of the unconscious to incorporate external influences into dreaming to keep the individual from waking up: the morning alarm becomes an ambulance siren, the pins and needles from an arm trapped under the body becomes a frightening disease eating away at one's flesh. Does this mean that, when I was interacting with Dale, I was in some sense entering his dream? I think that it does. Not infrequently would I say something to Dale, and get the distinct impression that he did not quite hear what I said, that my words and the inflection that carried them took on characteristics different from those intended. If the clock becomes a siren, what do my questions become? Here we can begin to implement Freud's (1900) strategies for interpreting dreams, and concepts such as condensation and timelessness become incredibly useful when attempting to interpret psychotic speech. The paradox is that, in this instance, interpretation is not necessarily an invitation to the patient to make contact with reality, but rather an invitation for both patient and therapist to enter the dream. It is impossible to simultaneously dream while having one's dream interpreted. In a sense interpretation is anti-dream, as it reveals what the dream may have worked hard to conceal. And the patient is deeply invested in not being 'woken' to reality. This is also why using one's countertransference, although disturbing, offers a representational space that does not threaten the patient's sleep, as it is on their terms (Bion, 1954). This space does, however, threaten the therapist's self-reflective function, their sense of themselves, and themselves as distinct and separate (Ogden, 1994). When we dream of a group of people, we play all the roles, we are in some sense all the other people as well as ourselves (Freud, 1900). For the dreamer the "I" (subject) and "me" (object) distinction blurs. In working with psychosis a similar blurring of this distinction seems to occur, leading to a breakdown of the therapist's self-reflective function (Ogden, 1994).

I am not sure exactly how the therapist is to hold and preserve both their own exploration and experience, as well as the patient's need for the existence of their dream world. I am, however, convinced that the two processes are not necessarily at odds: In the night a child calls out to their parents, petrified at their *truth* that the

monster that they have just dreamt about lurks under their bed. The monster is fictitious. The idea of it is real, as is the fear that it evokes. An explanation of the difference between dreams and reality, or a lecture on the impossibility of monsters will do no good. Only the validation of the child's experience of their own reality, carefully coupled with the reality of the vacant space beneath the bed will begin to put the child at ease. The risk to the parent, however, is that they might make contact with their own fear of monsters, or with their monstrous self.

'Adding value': The therapist's need

One of the aims of the therapy with Dale was to provide him with an opportunity to make bearable contact with humanity. The extent to which this aim was met remains undetermined. Dale's preoccupation with the idea of 'adding value' seemed to extend to the context of therapy. There were moments during our interactions that led me to believe that Dale did gain from a therapeutic intervention. In session 25 Dale recounted the death of his grandmother and his subsequent painful interaction with his father. Despite his initial seemingly flippant reaction to my suggestion that it must have been difficult news to receive, Dale allowed himself to be guided to what appeared to be a more vulnerable place, in closer contact with the painful reality of the loss. Also in this session, Dale explained that his family members bottled things up, and that this resulted in explosions. After being asked to what extent he did the same, he explained that he had me to talk to, which kept him from bottling things up. This reference to a very real relationship, as well as the reflections on both his family's and his own method of dealing with emotional difficulty, stand as clear examples of his ability to use the therapeutic space while being actively psychotic. Dale's attempt to hold on to the therapy space as shown in session 18 through his diary-keeping is another indication that he experienced the therapy as something worth holding on to. This was the same therapeutic space in which Dale was able, if only for moments, to move beyond the traditional impairments imposed by psychosis: Reality testing, as he was able to pick up on and follow social norms of interaction between us; Integration, as he recognised and commented on the real relationship between us, and held myself and the therapy in mind through diary keeping during my absence; Memory, as he held on to the content of our sessions and made reference to previous sessions and experiences; Perception, as Dale, at times, was able to focus on and react exclusively to the perceptual stimuli presented

to him in our sessions; and Judgement, as he often remained sensitive to my reactions to him, and began to understand and use the physical boundaries between himself and others (Arlow & Brenner, 1969).

I include this section of *adding value* to provide a stark contrast to the sections before. Here my countertransferential experiences of working with psychosis did not attack my organizing principles and self-reflective functioning, but rather fortified them. In my experience of working with Dale, I needed to feel (for reasons both conscious and unconscious) that there was value in the work I did, that it made a difference to him. This experience of value acted as a sort of offset to all the other intense and taxing experiences that I had to endure. My own experience of our therapeutic relationship, of Dale as a very specific individual made up of recognizable parts, and of how he allowed himself to be known by myself, were hugely valuable to me. He *allowed* me into his dream. Dale's projected ambivalence around being known and understood met the corresponding ambivalence in me. It may have invited or performed many countertransferential functions and communications, among them my own need to feel understood, or to be somehow involved in, or be the recipient of, a sustained effort to understand. The countertransference in relation to the psychotic is not *exclusively* disturbing and undoing. The sites within my unconscious world that represent my psychotic core are not without need and the hope of fulfilment.

At present, five years after our last session, Dale is back in the ward, having relapsed due to non-compliance. I have learned that he had not been admitted once during the five years, a very different picture compared to the time before our work together. I trust that our relationship, my allowance for his existence via my countertransference, had become a space that Dale could return to when he lost his grip on reality. This trust was in a sense legitimized when Dale walked up to me upon his arrival to the ward saying: "Hello Dr Nardus, do you remember me?"

CONCLUSION

This paper explored how engaging another individual's psychosis can evoke for the therapist countertransferential experiences that range from compassion and care to

confusion and terror, at times undoing the therapist's capacity to track, hold, and digest what is in the room. It has looked at various ways in which the therapist's sense of self and of reality can become fragmented and twisted as a result of entering worlds created by deeply disturbed individuals. Thought has been given to how the therapeutic tools used to help manage the difficulties experienced by more neurotic patients can seem somehow out of reach or undone in the face of psychosis, and how this state of affairs had left me feeling exposed and lost when confronted with my own countertransference. Importantly, there has been a focus on the therapist's experience of their self-reflective function coming undone, and on how this process forms an inevitable part of this type of work.

An analysis of a neurotic patient, among other things, aims to describe and explain the dynamic reciprocity between psychical forces, and importantly, to engage with repression (Freud, 1913). The inability to repress is one of the many losses psychotic patients suffer, and this opens the floodgates for a life through dreaming (Leader, 2012; Ogden, 2007). Do we, in some sense, begin our engagement with a psychotic patient where we would end off with a neurotic patient at the end of a successful analysis - a place where something has come undone? Jackson (2009) cites one of Freud's views on psychosis and therapy;

> *…So many things that in neurosis have to be laboriously fetched up from the depths are found in psychosis on the surface, visible to every eye. For that reason the best subjects for the demonstration of many of the assertions of psychoanalysis are provided by the psychiatric clinic...in the long run even the psychiatrists cannot resist the convincing force of their own clinical material (p.78).*

Perhaps the distinction lies in the difference that, for the neurotic patient, this place of having come temporarily undone signifies something of increased capacity to acknowledge the self in all of its facets, whereas for the psychotic it signifies an opposite and less transient place. What would an analysis in reverse look like, and what are the steps that one needs to take to help a psychotic patient to return to a place where they can repress, be defended, be self-aware enough to be embarrassed, and exercise choice? Importantly, what is the risk to the therapist in

this endeavour? I remain unsure of the answers to these questions. I believe, however, that regardless of where the patient is, they are to be found via the therapist's countertransference.

Paper 2: Psychoanalytic Psychotherapists' Experiences of Working with Psychosis

Introduction

This section begins the exploration of the interview material. The second article is an extension of the first in that it investigates the countertransferential problematics encountered by psychotherapists who work with psychosis, doing so via the experiences of eight psychotherapists.

Paper

ABSTRACT

Working therapeutically with people who experience psychosis can be demanding, confusing and even terrifying for psychotherapists, yet there is very little research that has systematically investigated the experiences of psychotherapists concerning their engagement with psychotic phenomena. Theoretically, it has been proposed that managing counter- transferential responses to a patient's psychosis is a crucial component of working psychoanalytically with such conditions. In light of this theoretical premise, the study reported upon in this article investigated some of the negative countertransferential dynamics observed by psychotherapists who engage in clinical work with patients presenting with psychotic states or conditions. Focused semi-structured interviews were conducted with eight psychoanalytically oriented psychotherapists. Two core themes emerging from the study are discussed: firstly, the psychotherapist's experience of madness; and secondly, the role of the body and somatic communication. The themes convey important aspects of countertransferential experiences related to the therapeutic encounter with psychosis.

Introduction

Psychotherapeutic interventions with people who experience psychosis have evoked fascination, confusion and strong resistance in practitioners of psychoanalytic psychotherapy (Bion, 1957; De Masi, 2009; Kongara, Douglas, Martindale, & Summers, 2017; Saayman, 2017; Schwartz & Summers, 2009; Stamm, 1995; Winnicott, 1949). In this paper, I attempt to further develop the understanding of reactions to working with psychosis by firstly, elaborating on two themes derived from interview material obtained from psychoanalytic psychotherapists, and secondly, linking these themes to influential literature on the subject. While there is a variety of approaches to

psychotherapy that could be used to engage the interview material, in this paper a psychoanalytic paradigm is used to guide the analysis given the focus on countertransferential dynamics. In addition, the arguments put forward draw primarily on the work of Wilfred Bion. A psychoanalytic understanding of psychosis can aid the psychotherapist in holding and making sense of what often seems like "mad and meaningless" communication and behaviour, providing trustworthy coordinates that guide the patient's return to health (Di Rocco & Ravit, 2015; Hinshelwood, 2014; Lucas, 2009).

There is a considerable body of psychoanalytic literature that focuses on understanding and working with psychosis as drawn together by Peciccia (2017). Within this body of literature, an area that has received limited attention is the systematic investigation of countertransferential challenges faced by those conducting psychotherapy with psychotic patients. The majority of studies investigating psychotherapists' experiences of their patients' pathology, regardless of the nature of the diagnosis, appear to explore experiences of individual psychotherapists based on anecdotal or observational accounts of case work (Coburn, 1998; Cornell, 2016; Dwaihy, 2016; Knoblauch, 2014; Lijtmaer, 2010; Reik, 1949; Stamm, 1995; Steinman, 2009; Szasz, 1956; Zuckerman & Horelick, 2006). Coburn (1998) expanded on Kernberg's (1965) observation that phenomena such as projective identification and countertransference are core components of any psychotherapeutic endeavour, noting that attention to these processes remains an indispensable part of any analytic process. Kernberg's (1965), Goldberg's (1979) and Coburn's (1998) papers on therapists' responses to intense psychotherapeutic exchanges also highlighted the often problematic use of the terms projective identification and countertransference, and the inclusion of definitions that drift away from the psychotherapist's reactions (both conscious and unconscious) to the patient. In investigating psychotherapists' experiences of working with psychosis, this paper examines aspects of both projective identification (defined for this paper as the therapist's unconscious experience of, identification with, and acting out of the patient's projections) and countertransference (defined for this paper as the therapist's unconscious response to the patient's internal world) as examples of therapist's experiences of working with psychosis, and not as the sole representations thereof.

The literature suggests that working with psychosis can evoke intense disturbances for the psychotherapist (Evans, 2016; Martindale, 2017; Saayman, 2017; Stamm, 1995). Psychotic projec- tions can be particularly distressing and difficult for the psychotherapist to receive and digest (Evans, 2016; Saayman, 2017; Stamm, 1995). These projections are usually fragmented and are often not rooted in particular times, places or interchanges, making it difficult for the psychothera- pist to orientate themselves (Bion, 1957). Bion (1956) spoke of how the function of speech in psychosis can unpredictably fluctuate between communication, thinking and action. He also formulated the idea of the significance of "attacks on linking" – related to the observation that in some instances the patient attempts to undo the therapist's capacity to think (Bion, 1957). Segal (1957) explained that psychotic patients suffer a breakdown of their ability to symbolize, to retain the "as if" function of metaphor in communication, placing the psychotherapist in a position where symbolic work may become precarious or even dangerous.

One of the most fundamental psychoanalytic works on psychosis, Freud's 1924 paper called Neurosis and Psychosis, traces psychotic communication to a "rent in the ego", where such communication is understood to flow freely from the unconscious, demanding extreme responsive creativity from the psychotherapist, as well as a willingness to suspend their often narcissistic need to understand and interpret. In psychoanalytic theory, all individuals, including the therapist, are believed to have a psychotic core, a part of the self that remains in flux, potentially bringing the psychotic individual's disturbances into close proximity (Bion, 1957). It is against the backdrop of these and other valuable and significant psychoanalytic notions of what characterizes and influences the experience of the process of psychotherapy with psychotic patients that I investigated psychotherapists' self-reported experiences of working with psychosis.

Aims

The aim of the research was to explore the experiences of psychoanalytically oriented therapists working with psychotic patients (in this instance based in Johannesburg, South Africa) via focused interviews; to identify common themes that emerged across participant accounts; and to locate these themes in relation to the existing body of psychoanalytic theory on working therapeutically with psychosis.

Methods

Research approach

The study was qualitative, lending itself to researching the nature, quality and effects of therapists' experiences of working with psychosis. This approach allowed for the collection of information on each participant's experience in the specific subjective context within which it occurred (Fossey, Harvey, Mcdermott, & Davidson, 2002). A qualitative design also allowed for the study of a complex phenomenon in psychotherapy (Fossey et al., 2002), in this instance countertransference in the therapeutic treatment of psychosis. An interpretive research paradigm was applied, which accommodated the subjective nature of the research (Fossey et al., 2002).

Sampling

Non-probability, purposive expert sampling was used. This ensured that psychoanalytically orientated psychologists with intensive experience of working therapeutically with psychotic patients were interviewed. A non-random sample also ensured investigation of the experiences of a specific group and yielded information that was valuable for the purpose of the specific study (Fossey et al., 2002). In order to allow for an in-depth inquiry into the experiences of the respondents, a relatively small sample of eight psychoanalytically orientated psychologists were interviewed (Fossey et al., 2002).

Inclusion criteria included the following: registration with the Health Professions Council of South Africa as a clinical, counselling or educational psychologist; training in a psychoanalytic approach to psychotherapy; and experience of having worked for at least 5 years with psychotic phenomena or conditions within clinical practice. The

respondents form part of my broad collegial network and were recruited via word-of-mouth invitations circulated amongst practitioners associated with the South African Psychoanalytic Confederation.

Data collection

I conducted face-to-face, semi-structured, individual interviews with the eight participants who volunteered to take part, using open-ended questions that allowed for probing and the generation of rich information (Fossey et al., 2002). The interview schedule was based on the broad aims of the research and was developed in consultation with a clinical-researcher seminar group based at the University of the Witwatersrand. The questions were tested in a pilot interview conducted with a clinical psychologist in Johannesburg who has experience of working therapeutically with psycho- sis. As the pilot interview produced rich data and yielded no unforeseen difficulties that rendered the data captured unsuitable for use, it was included in the study. Respondents were interviewed once at my private practice in Johannesburg for between 1–2 h.

Data analysis

An inductive analytic approach was used ensuring that I remained open to the respondents' possible views and experiences and to ways of making sense of their accounts, without imposing predetermined notions of pathology or intervention regarding psychotic phenomena (Fossey et al., 2002). This approach allowed for the data to direct the analysis as the study was exploratory, aiming to generate insights from the observations of practitioners themselves. However, the analysis also included certain more deductive elements such as working from the initial premise that psychotherapists themselves may be susceptible to psychotic-like experiences when working with a patient's psychosis.

The thematic analytic approach of Braun and Clarke (2006) guided the data analysis. Coding categories and preliminary themes were established on initial reading of interview transcripts, and subsequently refined on the basis of rereading of material and comparison across interviews, allowing for higher-order themes to emerge from the interview corpus as a whole (Braun & Clarke, 2006). Two of the core themes that emerged are discussed in this paper. They were selected for discussion here as they speak directly to the original aims of the paper in that they highlight experiential difficulties in working therapeutically with psychotic phenomena in the room.

Findings

Theme 1

The therapist's experience of madness

Searles (1963) explained that, when engaging their patient's psychosis the psychotherapist is bound to be faced with a brutal confrontation with their most primitive anxieties and fears of disintegration. Evans (2016), in looking at why psychotherapists might be reluctant to engage therapeutically with psychosis, noticed

that it seems to be safer to do therapy with psychotic individuals when the psychotherapist is removed from the disturbance.

Participants 1 and 8 spoke to this need to distance from psychotic elements in patients:

> People don't want to know that place in themselves, they want those things about themselves to be alien, not me. (P1)

> I think that people, when they see psychosis, they see something in themselves that petrifies them, you know, the psychotic core, the primitive grain of how we're born and how hard it is to build the mind. (P8)

Comparing this dynamic to other categories of psychopathology, Participant 1 went on to say:

> This is so other, this is so uncanny, so other, so psychotic, you know I mean we can even do that with personality disorders. 'This is not me, I am not narcissistic'. Bullshit, we are all narcissistic, you know, so we can do it with things like that, narcissism, you know, but then psychosis is like way out there.

These comments indicate that working with psychosis produces particular kinds of anxieties for therapists (petrifies them) and that the need to disidentify with such patients is very strong, as psychotic phenomena are experienced as alien, uncanny and way out there. Participant 1's reference to the fact that one is confronted with how precarious it is to develop a functional mind is also instructive as it acknowledges that breakdown is a possibility for all human minds.

In reviewing the interview material, the theme of the psychotherapists' experience of their own madness emerged – a multifaceted theme comprised of four sub-elements: When Thinking Fails; Difficult Close Encounters; Breakdown in Experience of Reality; and Failing to Differentiate between Self and Other.

When thinking fails

Bion (1957) spoke of the psychotic patient's hatred of internal and external reality and of their destructive wish to do away with their experience of these realms. He also described the fragmented nature of the psychotic patient's projections – projections made up of minute pieces of the patient's self, of their internal objects and of their experiential faculties and meaning-making parts (1956, 1957). When deeply defended against any kind of reality, the patient does not welcome thinking that could lead to an experience of reality, and this has an impact on the therapist (Bell & Novakovic, 2013; Winnicott, 1949). Participant 2 captured something of the anti-thinking nature of a psychotic space:

> Psychosis is . . . it's something regressive, to the realm of the maternal. And so the maternal as representative of the irrational, the emotive, the semiotic thing, that swamp, kind of, it's a place where I can really struggle to hold onto my mind.

The reference to that swamp suggests that metaphorically one can be sucked into something dangerous. This attack on the psychotherapist's ability to think can be extremely daunting (Bion, 1956, 1957). Participant 3 reflected on their personal reaction to this kind of dynamic:

I think the defense is very strong, I think, partly, the defense, my defense would be obviously to . . . you don't want to go there, because it is a mad space to be in, so your mind would shut off in response to another person's mind going mad.

Difficult close encounters

Another factor that emerged as part of the psychotherapists' experience of madness was the powerful experiences of their patients getting too close to them. The difficulties involved in negotiating closeness encapsulate so much of what the psychotic individual has to deal with. Lacan ([1938] 2003) saw psychosis as the outcome of a failure to process the invasion of others.

Participant 3 recounted a sense of being invaded:

It gets hectic, I think partly it's because it cannot necessarily be spoken about. It . . ., um, it feels very intrusive, I don't know if it is that as well, I do think it mirrors something about how they feel at times, how they get intruded upon, but I think it's almost like wanting to get into your skin and into your mind . . . and your instinct is just saying 'I don't want this, I want you to stay somewhere else', but it's about just thinking about that. (P3)

Participant 3's account resonates with Searles (1963, 1973) description of the psychotic patient's wish to enter the psychotherapist, to insert themselves inside their body, either to be intimately known or to replace and destroy the psychotherapist's insides. Again one has a sense of the therapist's powerful need to escape this pressure and the need to survive this kind of primitive interaction.

Participant 5 described the extreme nature of their experience of their own body shutting down as a result of their close proximity to madness:

I saw this adolescent guy, who had very intricately, very constructed worlds. And it was hard to listen to, to get close to, I used to literally feel like the front of my eyes were peeling off and what it was in reality was my eyelids closing as I fell asleep, but my experience of it was that the front of my eyes were peeling off and falling down my face.

In this instance it is the experience of attempting to enter the patient's complex world, to get close to this adolescent, that then leads to a sense of disintegration and a disturbance in reality, as further discussed in the next section.

Breakdown in the therapist's experience of reality

The psychotherapist's experience of madness is further influenced by an engagement with the patient's relationship and response to consensual reality. The psychotic individual's ability to trust their own sensory experiences frequently fails (Arieti, 1957; Bion, 1954; Kernberg, 2003; Lampshire, 2012; Robbins, 2012). The patient struggles to differentiate between reality and fantasy, as their experience is dominated by primary process functioning, by omnipotence and omniscience (Bazan, Van Draege, De Kock, Brakel, Geerardyn & Shevrin, 2013; Freud, 1900; Robbins, 2012).

Participant 4 gave a powerful account of engaging with their's patient's reality:

I find it really, really creepy, I find that it freaks me out. I get very kind of . . . I get scared by it. So there is a case that comes to mind. Umm, I was working with this little boy, violent little boy, very, very disturbed kid and he would, so we were playing this ball game and you know I was talking to him about the ball game and I started to do normal interpretive stuff which of course started to mess with his Jenga

construction and what happened was that he then started to become extremely frightened and extremely distressed and he said to me: "What have you done with the ball?" And initially I thought this kid was joking, because the ball was there right there between us and he said: "What have you done with the ball?" And he literally had a break, a kind of a break in reality that his perceptual capacity had been attacked and this ball had disappeared and it was terrifying for me, to actually be in relation to this child, looking at this ball. He couldn't see it, for him it had disappeared a, like a thing and it was really, really freaky, scary, awful. It made my skin crawl. I thought "what is going to disappear next, is he going to disappear? Am I going to disappear? Is the room going to disappear?

In this instance, the therapist talks about a visceral response (It made my skin crawl) to the experience of a loss of reality contact on the part of the patient in an immediate interaction. In this instance, the child experiences the disappearance of the ball, and in a somewhat paranoid vein believes the therapist has done something with it. Participant 4 describes how the child's conviction alters his/her own sense of reality to the extent that everything feels insubstantial or at risk of disappearing. Di Rocco and Ravit (2015) stated that psychotherapists who engage in work with psychotic patients need to be able to survive contact with psychotherapeutic dynamics that disturb, as well as with their own introjects and archaic structuring experiences – an engagement dissociated from logical thought that will undoubtedly influence the capacity to test reality and track patients (Robbins, 2012).

Participant 6, in also providing an account of being pulled into psychotic perception, explained that they had to continuously reel themselves back from what felt like an engulfing alternate reality. During placement on a male psychotic ward, this participant would actively ground themselves on a daily basis:

I needed to, to consistently be anchoring myself in a reality Also though, when I was driving to work I needed to say 'I'm driving to work, this is a reality' and when I was speaking to someone, I needed to almost to have an ear listening to, are my sentences logical? It was heavy, and I think at that point I was confronted with working day in and day out with the subjective realities, the strong and pervasive subjective realities of others.

Failing to differentiate between self and other

A breakdown in the psychotic individual's capacity to distinguish between themselves and others, and the psychotherapist's experience of this dynamic further informs the experience of madness (Segal, 1957). During one psychotherapy group with psychotic male inpatients, Participant 6 had an experience of a patient turning to him and telling him that his father, who in reality had died, missed him and that he had not visited the grave site despite carrying his surname.

The psychotic experience in that moment was that I engaged with him almost as though it was an absolutely real communication. Because of how I aligned and thought of my reality in that moment, he was not speaking . . . he was not being irrelevant and illogical and psychotic and delusional, he was being absolutely real, kind of he was being honest, he was giving me a message. Um, in that moment, and I understand that and it was frightening, it was frightening in that interaction, in the looking into my eyes and telling me that as well as in the afterwards, 'like what happened there?' It was terrifying.

Here Participant 6 notes how terrifying it was to become engaged in a manner in which his reality in relation to time, consanguinity and personal history became distorted on the basis of the patient's compelling communication and positioning of him/her. Bollas (1983) deemed tolerating these levels of disturbance as necessary to the therapeutic process with psychotic patients. If the therapist wants to be able to find and connect

with a patient in the place of madness, this implies the possibility of a deeply disturbing experience for the therapist (Bollas, 2015, 1983), as confirmed in the kinds of intense experiences volunteered by participants.

Theme 2

The role of the body

The role of the psychotherapist's body in the therapeutic encounter, and the importance of using bodily experience to make sense of what is happening for the patient have been formalised and established in psychoanalytic theory (Goldberg, 1979; Gubb, 2014). In the psychoanalytic tradition, the regression that occurs when an individual becomes psychotic marks a return to the first year of life, to the oral phase (Freud, 1924; Klein, 1935, 1946). This is a time before the formation and use of symbols (the somewhat arbitrary language-based structures that stand for the things that are represented), before the formation of a mind capable of symbolic thought, a time where experiences are fundamentally bodily (Bion, 1956; Freud, 1924; Klein, 1935). Here the infant communicates via projective identification, and specifically via projections that are not, at first, thoughts or symbolic constructs, but rather, feelings (Bion, 1956; Klein, 1935). These projections are what Bion (1954, 1956)) would call Beta-elements, communications that may or may not be rendered into intelligible Alpha-elements. Beta-elements, when projected, are experienced via the body, not via the mind (Goldberg, 1979; Grammatopoulos, 2017). In later life, the psychotic individual can regress to a place where they are stuck with a body that is made up of words, or the idea of organs, rather than actual organs – stuck without a "real" body and without the capacity to think about it (Goldberg, 1979; Grammatopoulos, 2017).

Participant 5 spoke of a patient who could not think, and who did not seem as though she could be thought about as a real person with a real body:

> It was about a delusional dynamic, and I was not sure what was going on, so what is it if it's not a thought? Or if it's not a remembering, or if it's not a representation of . . . of what happened? Umm . . . it's something about the body, you know that it's almost as if she doesn't inhabit a body, but everything is about feeling, which is the body.. . . And it just felt so alien, umm, and it was intense, umm, and it, as I say, you know, it had no context, it was just such a bodily feeling of this, this energy, this ... umm ... terrible energy ...that had no meaning, no context, no, nothing sane about it. And I.. . . I was a bit worried that I was going crazy, umm . . . because it had never happened before, and it has never happened since, that kind of intensity.

The theme of the "role of the body" is elaborated on under two sub-dimensions: A Dead Space, A Tired Space; and Primal Hunger.

A dead space, a tired space

In the psychotherapeutic encounter, the patient frequently benefits from the therapist's ability to think about and navigate difficult affects and experiences. This function has been referred to as an auxiliary ego function and encompasses the therapist's holding and containing functions (Freud, 1905; Hoffman, 2013; Winnicott, 1960). In psychosis, the patient's own ego function is severely impaired (Bion, 1954; Freud, 1924; Lucas, 2009; Robbins, 2012). In reflecting on their experiences of providing their own minds as

an auxiliary ego for the struggling psychotic patient to draw on, Participant 2 seemed to make contact with a very powerful process:

> It feels too heavy, and it feels for me like dead space... in a strange way those cases become alive when they become floridly psychotic, because suddenly there is, there's interesting characters in the play, but in the other periods there's often for me this dead heaviness, a black hole, anti matter, that I think of as an implosive rage.

While the comment about psychosis and aliveness is interesting, what is emphasized here is the feeling of physical heaviness (dead heaviness) associated with carrying something primitive and un- symbolized (antimatter), in this instance perhaps in relation to negative symptoms of psychosis. For Participant 2, it is evident that the work required in the process of therapy with a psychotic patient is enormously taxing: "it's not something I want to do a lot of, I get tired from that."

Similarly, Participant 7 reported,

> I find myself doing much more work, they're almost easily going into like an automatic mode, like where you just talk about your day, or that you remind yourself that you are doing psychotherapy or there is something to work with and I feel I'm sometimes . . . tired, almost like overwhelmed by not knowing where to start or where to go, and like not even feeling, its difficult to explain just the feeling.

Even representing this difficulty dynamic retrospectively seemed like hard work for Participant 7:

> I feel like I can't explain to you with other words how I feel, like I did however you're asking me for a feeling, and I cannot put in a feeling word, I can put in images, metaphors, but I don't have a feeling that can capture, it's not sadness, it's not happiness, it's not hopelessness, it's just 'oh I need to move this mountain with my hands, which will take forever.

The image that Participant 7 is able to find is powerfully evocative in terms of conveying some- thing of how overwhelmingly effortful the task of working with psychosis is.

Primal hunger

The psychotherapeutic process involves what the therapist has to absorb and process from the patient, as well as what the patient can or cannot take in from the therapist. Different terms are used to describe the process of give-and-take in therapy. Amongst these are introjection, incorporation, identification, ingesting, metabolising, integrating, absorbing and assimilating. We use the terms interchangeably, as did Freud, and Klein, and many other analytic writers (Brody & Mahoney, 1964). I want to focus here on the idea of metabolising, specifically on the therapist's ability receive the patient's projections and contain them, think them through, and offer them back to the patient in a meaningful, manageable and potentially transformative manner (Winnicott, 1960). Here I return to the specific notion that the development of psychotic disturbances has their root in the first year of the patient's life, in a time where experiences are fundamentally bodily (Bion, 1956; Conway & Ginkell, 2014; Freud, 1924; Klein, 1935). Hunger frequently dominates the infant's bodily experience, and, while present, captures the entirety of the infant's experience (Winnicott, 1960). The intensity of the infant's experience of hunger becomes a pain that signals something frightful (Klein, 1946). In these instances, the infant may experience intense annihilation anxiety, and

the fear of disintegrating (Klein, 1946). Psychoanalytic theory suggests that, if the infant's overwhelming experience of the distress that hunger brings is not mediated by a thoughtful and containing other, there is a considerable risk for the development of psychotic structures and defences as a result of the maternal failure (Conway & Ginkell, 2014; Winnicott, 1952, 1963). If it is accepted that psychosis, in part, takes one back to the origins of life, and that the experiences of that place are intense and bodily – related strongly to hunger and feeding – this may be reflected in the therapist's countertransference (Goldberg, 1979).

Participant 8 spoke of their experience of working with a group of psychotic in-patients:

I listen to them, and it's a loosening of associations and it's a kind of, and that loosening is a loosening of reality, reality becomes a bit more porous, I try and trap what I am feeling inside whether it be hunger or fatigue, and I have been trying to trap the hunger and the fatigue and I notice that I get hungry when things start to make sense again, even though not necessarily coherent sense, but when there's a sense making process that emerges.

Participant 6 reflected on his experiences in a male psychotic ward, relating his experience of fear to that of a terrified infant:

It's just the terror, it's almost like an infantile terror when they feel hungry, we say they are hungry and therefore they are terrified in the formulation of why they're screaming, though in that moment on almost a subjective experience of, it is just terror, it's not hunger, cause it cannot be located in something. It's just form.

In these instances, the therapist is placed in a position where they need to hold and digest the patient's intense annihilation anxiety and the terror of disintegrating (Davidsen & Rosenbaum, 2012; Hurvich, 2003; Lampshire, 2012).

Discussion

From both existing literature and current treatment guidelines, it is suggested that there is long- standing resistance to engaging psychotherapeutically with psychosis (De Masi, 2009; Kongara, Douglas, Martindale, & Summers, 2017; Martindale, 2017). This study provides a contribution to the development of an understanding of countertransferential disturbances that result from engaging psychotherapeutically with psychosis. The accounts gathered within this study provide valuable insights into what psychotherapists who do engage with psychotic patients experience, contributing towards an understanding of points of potential resistance. The study found that working with psychotic phenomena can evoke powerful and often disturbing countertransferential experiences. Two key challenges were the participants' experience of the breakdown of their capacity to think, and the experience of concrete and visceral effects where powerful bodily distress became prominent. Participants provided striking accounts of having to hold and survive extended dis- comfort and distress brought on by overwhelming confusion, fatigue and consuming emotional states, without recourse to the alleviation brought on by reflection and meaning-making. Of particular interest was the manner in which the participants reflected on their experiences. These are smart and articulate professionals. They think and talk for a living, yet many of the experiential accounts demonstrated how difficult it can be to comprehend and intelligibly articulate these

experiences. It is apparent that working with psychotic phenomena can be deeply disturbing for the psychotherapist, and that the difficulty of holding the disturbances is, at times, compounded by the undoing of the psychotherapist's mind and self-reflective capacity. The respondents did not, however, indicate that the disturbances experienced, although challenging and sometimes over- whelming, were necessarily counterproductive, or counter-therapeutic. Rather, the thoughtful accounts suggested that encountering such disturbances is part of what it means to engage therapeutically with psychosis.

Implications for further research

Continued contributions to the growing literature on how psychotherapists can position them- selves in relation to psychotic phenomena and their experiences thereof are needed. Specifically, further investigation into the bodily phenomena experienced by both the psychotherapist and the patient is warranted.

Limitations

As there is very little literature on therapists' experiences of engaging with psychosis to use as a check, strengthening the external validity of this study proved difficult. However, the findings were located in relation to related empirical studies (e.g. Connolly & Cain, 2010), and to existing psychoanalytic literature on therapists' accounts of working with severe psychopathology. The quality, validity and the authenticity of this study were naturally affected by the extent to which interpretations were made from the information gathered (Fossey et al., 2002). Further limitations of the study also include the exclusive deployment of a psychoanalytic framing of the data and the relatively small sample size.

Strengths

Given the relatively limited literature exploring experiential accounts of psychotherapists' experiences and understandings of working with psychotic patients, the study offers a novel contribution.

Disclosure statement

No potential conflict of interest was reported by the author.

Paper 3: Psychotherapists' Experiences of Withdrawn Psychotic Patients

Introduction

One of the dynamics identified in the interview material was that of the psychotic patient who has withdrawn from the external world. Again the section builds on the previous one, and focusses on particular difficulties that psychotherapists report on that have impacted on their experiences of the construction and functions of the therapeutic relationship with psychotic patients.

Psychotherapists' experiences of withdrawn psychotic patients

ABSTRACT

Psychotic patients frequently struggle to relate to the external world and to others, including their psychotherapist. This does not imply that there is no attempt at relating, but rather that the attempt does not seem to acknowledge the full existence of the psychotherapist as other. If the patient's attempt at relating is missed, they are at risk of being abandoned to the dread of their separation and loneliness. Psychotherapists see the process of establishing some form of relationship with their patient as a key component of a viable therapeutic endeavour. The point at which the withdrawn psychotic patient and the psychotherapist meet potentially marks the beginnings of relatedness disturbed by conflicting needs and wishes, the experience of which can potentially deter psychotherapists from further engagement. In this paper, psychodynamic psychotherapists' accounts of engaging therapeutically with withdrawn psychotic patients are used to highlight therapists' experiences and reactions to the specific phenomenon of withdrawal encountered in some psychotic patients. This dynamic is explored via the interaction between the therapist's multidetermined need for relatedness and the patient's psychotic withdrawal, and is dis- cussed via three themes; The therapist's need for relatedness, The therapist's ego strength, and Reviving relatedness.

Introduction

There is something about engaging therapeutically with psychosis that can potentially disturb the psychotherapist (Bell & Novakovic, 2013; Bion, 1957; De Masi, 2009; Kongara, Douglas, Martindale, & Summers, 2017; Saayman, 2017, 2018; Searles, 1963). This "something" can include: the patient's inability or unwillingness to acknowledge and react to what would be considered consensual reality (Evans, 2016); the patient's powerful and fragmented projections (Bion, 1957); the unpredictable chopping and changing of the meaning and use of words (Bion, 1957); and the heavily taxing nature of working with a patient with a profoundly impoverished ego (De Masi, 2009; Freud,

1924). Meeting, following, tracking, and attempting to understand a patient that makes contact in such seemingly perplexing ways can present the therapist with a challenging yet potentially rewarding task that often demands patience, creativity, and stamina (Evans, 2016; Saayman, 2018; Stamm, 1995). The potential difficulties involved in working with psychosis can be further complicated if the patient exhibits psychotic withdrawal – a symptom that can render the forming of a therapeutic relationship very challenging. There is a significant lack of literature that explores psychotherapists' experiences of working with psychosis, which makes an inquiry into this topic particularly important.

In this paper I define psychotic withdrawal as the patient's inability and/or unwillingness to connect to the people around them, including the therapist. This definition is extremely broad and focuses less on the complex and multifaceted phenomena of psychotic withdrawal, which I believe can be the result of many different factors, and more on the consequence of the patient not relating to other people – a lack of relatedness. I don't view psychotic withdrawal as the hallmark of psychosis, but rather as one of its possible symptoms. Psychotic withdrawal can be understood both as the patient's act of defence and of attack, and includes what the psychotic patient withdraws into, be it hallucination, delusion, obliteration of experience, or other forms of defence or attack (Meltzer, 1982). For the purposes of this paper I will not provide in-depth focus on the specific motivations or goals of psychotic withdrawal, as these aspects do not speak to the paper's aims.

Psychotic withdrawal can potentially be very difficult to work with as it often takes a long time to resolve, and tenaciously reorganises to maintain its hold (De Masi, 2006). This can have a profound impact on the therapeutic scene and on the therapist's capacity to establish a therapeutic relationship (De Masi, 2012; Thanopulos, 2008). The apparent absence of the patient's representation of their subjective and personalized experience can create in the therapy the therapist's perception of a missed encounter, an experience that may be diagnostically relevant as it alludes to the patient's withdrawal (Thanopulos, 2008). What is absent in the "missed encounter" can be referred to as relatedness, closeness, or connection, and these terms are often used to denote a variety of elements that, among other factors, contribute to and make up the therapeutic relationship (Stierlin, 1964). It has been well established across the theoretical divide that the therapeutic relationship plays a crucial role in the success of any therapy. In this paper I focus on what the therapist may need from their patient to facilitate the establishment of a therapeutic relationship. The needs of the therapist in relation to their patients are manifold. The specific need that I focus on here is the therapist's need to establish a form of relatedness with the patient. Naturally this need cannot be easily defined and standardized due to the many variables pertaining to the therapist's personality, style of working, theoretical orientation, and the complexities created by the specific relational experience (or lack thereof) with a specific patient under specific circumstances. However, for the purposes of discussion I define the need of the therapist to relate broadly, as the need to establish rapport and create the circumstances for the development of a therapeutic relationship, and more specifically, as the therapist's need to feel efficacious. Kernberg (1970) emphasised that we all have (healthy) narcissistic needs, such as to be appreciated, valued and seen. Psychotherapists in particular may enter the profession because it satisfies some of these healthy narcissistic needs, meaning that psychotherapists are required to

interrogate their narcissistic vulnerability (see e.g. Chused (2012), Coburn (1998) and Thomson (1993)). The aim of this paper is not, however, to interrogate psychotherapists' narcissism, but rather to investigate how the specific phenomenon of psychotic withdrawal could potentially leave the therapist with an experience that deters them from persevering in their attempt to establish some form of relatedness with their withdrawn psychotic patient. With this aim in mind I will use interview material obtained from psychotherapists who work with psychosis that illustrate the therapists' experiences of psychotic withdrawal and discuss the possible implications of these experiences.

Aims

The overall aim of the broader research project was to explore the experiences of South African psycho- analytically oriented therapists working with psychotic patients. More specifically, the study aimed to identify factors intrinsic in working with psychosis that could potentially result in negative therapist experiences and a subsequent avoidance of treating patients suffering from psychotic disorders.

Methods

Research approach

The study was qualitative, as the focus of the research was on the characteristics and quality of therapists' experiences of engaging psychotherapeutically with psychosis. The use of a qualitative design allowed for the study of complex components of psychotherapy, such as the psychoanalytic treatment of psychotic disorders. The use of an interpretive research paradigm accommodated the subjective nature of this research, foregrounding the importance of attempting to uncover and comprehend the nature and meanings of the respondents' experiences (Fossey et al., 2002; Schwandt, 1994).

Sampling

Non-probability purposive expert sampling was utilized, helping to ensure that psychoanalytically- orientated therapists with appropriate experience in working with psychotic individuals were inter- viewed (Palys, 2008). Additionally, a non-random sample aided the investigation of the experiences of a select group, potentially yielding data that is more valuable to the aim of the research than information gathered from a random group. Eight psychoanalytically-orientated psychologists were interviewed. The following criteria guided inclusion: Registration with the Health Professions Council of South Africa (HPCSA) as a clinical, counselling, or educational psychologist; training in a psychoanalytic paradigm; and experience and a willingness to engage therapeutically with psychotic individuals. The respondents form part of the researcher's professional network.

Data collection

A self-designed semi-structured interview was used in once-off face-to-face interviews, enabling the use of open-ended questions and probing in the service of generating richer information (Singer & Cooper, 2017). The aims of the study guided the content of the interview schedule, which was designed based on input from the university's clinical panel and ethics committee. I interviewed all respondents in my private practice in Johannesburg.

Data analysis

To help ensure that I remained open to the participants' possible views and experiences, as well as to the multidimentionality of their experiences without imposing preformulated ideas of psychopathology or interventions regarding psychotic phenomena, an inductive analytic approach was used. (Fossey et al., 2002; Varvin, 2011). Using an inductive analytic approach allowed for the analysis to be guided by the data, as the study was exploratory in nature. However, the analysis was influenced by particular deductive elements that include the initial premise that psychotherapists themselves stand to be susceptible to avoid working with psychotically withdrawn patients as a result of the difficulties inherent in attempting to establish a therapeutic relationship.

The data analysis was further guided by the thematic analytic approach of Braun and Clarke (2006). Preliminary themes and coding categories were identified during an initial reading of inter- view transcripts. These themes were then refined by re-reading the material and comparing across the interviews. This allowed for higher-order themes to develop from the interview corpus as a whole (Braun & Clarke, 2006). Three of the core themes that emerged were selected to capture a particular phenomenon – psychotherapists' frustrated responses to psychotic patients' withdrawal. These form the basis of this paper. The first theme, "The Therapist's Need for Relatedness", was found in the material of participants no2, no3, no5, no7, and no8, (5 out of 8). The second theme, 'The Therapist's Ego Strength, was found in the material of all of the participants. The final theme, 'Reviving Relatedness, is a theme constructed by myself in relation to both theory and the previous two themes, and is illustrated in this paper by the interview material from participants no1 and no5.

To control for researcher-bias the process of selecting and interpreting data was overseen by my research supervisor. Further input and evaluation of the development and writing of this paper was provided by the university Psychoanalytic PhD cohort that I am part of. This cohort consists of other PhD candidates and the senior academic staff that act as supervisors on the program. Both the researcher supervisor and the PhD cohort elicited and provided input on the ideas, experiences, prejudices, and theoretical preferences that I brought to the interpretation of the data to improve the likelihood of identifying and managing researcher bias (Campbel, Quincy, Osserman, & Pederson, 2013; Norris, 1997).

It is significant that 6 of the 8 participants spontaneously reflected on the difficulty of engaging with withdrawn psychotic patients, as the phenomenon of psychotic

withdrawal was not included in the questionnaire and was not rendered an area of focus by myself during the interviews.

Situating the findings

The psychotherapist's need for relatedness

The relationship between psychotherapist and patient is a complex and nuanced phenomenon. My intention is not to reduce the intricacies of this relationship to the therapist's need for relatedness and the extent to which the patient meets this need, but rather to focus on a particular aspect of the therapeutic relationship – that of relatedness, via the psychotherapist's proposed need for related- ness as experienced in relation to a specific patient – someone lost to psychotic withdrawal. The psychotherapist's need for relatedness exists within the context of the establishment and function of the therapeutic relationship. Defining the characteristics and components of what does and what does not contribute to the therapeutic relationship is a complex undertaking dependent on theoretical stance. Much of psychoanalytic literature is devoted to this topic, and the aim of this paper is not to distil the concept of therapeutic relatedness to its true components. For the purposes of this paper I will employ Meissner's (1999, 2007) definition of the therapeutic relatedness as including; transference (the patient's unconsciously driven experience of the therapist), counter-transference (the therapist's unconscious reaction to the patient), the real relationship (who the therapist and the patient are to each other outside of the transference-countertransference dynamic), and the therapeutic alliance (the pact between the therapist and patient to engage in analytic work for the good of the patient).

Broadly speaking, the therapeutic relationship and the relatedness that occurs within it provides both the setting and structure within which psychotherapy occurs (Stierlin, 1964). This means that both the patient and the therapist need the development of relatedness, whatever form this may take, in order for therapy to occur. Psychotherapists may need the patient to contribute to a reciprocal experience of relatedness for a variety of reasons that include: what is needed to establish a working relationship; the therapist's reactions to the complications brought on by the patient's narratives and projections and the therapist's conscious and unconscious reactions to the material; and the therapist's own personal need for relatedness in order to experience themselves as an effective therapist. No psychotherapist can be exempt from being vulnerable to their needs of their patients (Chused, 2012; Coburn, 1998; Thomson, 1993). The therapist's need for relatedness and the frustration of this need by a psychotically withdrawn patient potentially sets up a particular kind of clinical phenomena that I wish to illustrate via the interview material. First, I will situate psychotic withdrawal.

Psychotic withdrawal

Withdrawal occurs in a large proportion of cases of complex borderline and psychotic psychopathology (Bleger, 1974; De Masi, 2012). It can result in severe distortions in the individual's psychic functioning and often leads to devastating loss of interpersonal relatedness and a distortion in psychic functioning (Arieti, 1966; Bleger, 1974; Cullberg,

2006; De Masi, 2012, 2017; De Masi, Davalli, Giustino, & Pergami, 2015; Green, 2012; Roussillion, 2010; Steiner, 1993).

Psychoanalytically, psychotic withdrawal has been described in a multitude of ways using various theoretical notions. This process of psychotic withdrawal can be linked to Freud's (1905, 1914) formulation that psychosis, with its break from reality, can be understood as a regressive return to primary narcissism, to a space and time where the infant enjoyed the pleasures of omnipotence (Freud, 1905, 1914; Roussillion, 2010; Winnicott, 1965). For Freud this state of primary narcissism is one that we all have access to, and which is fundamentally different from the narcissistic disturbances suffered by personality disordered individuals. The concept of primary narcissism remains helpful for thinking psychoanalytically about psychotic withdrawal (see e.g. Garfield, 2011; Goldman, 2012; Roitman, 2017) although the original assumption that the roots of psychosis can be found in disturbances of primary narcissism has been challenged. Viewing psychotic withdrawal as a return to primary narcissism holds the potential to disregard other factors that contribute to withdrawal, such as the patient's potential fear of being overwhelmed by the other and disintegrating (Stierlin, 1964). My aim here, however, is not to define the origins and causes of psychosis, but to highlight the narcissistic nature not just of psychosis, but of psychotic withdrawal specifically (Solms, 2016). I am focusing here on a particular component of psychosis, looked at through a specific lens, as this view lends itself to a useful juxtaposition of the potential needs of the psychotherapist to establish some form of relatedness, and the psychotic patient's narcissistic withdrawal – in a sense the antithesis to real relatedness.

Freud understood psychosis as the result of failed or unresolved primary narcissism, or a return to primary narcissism via regression, because the illness mirrors so much of what makes up this developmental phase – the omnipotence, the megalomania, the belief in a world of one's own making, the lack of relationships and relating, and the withdrawal into the self (Amir, 2010; Cortina, 2015; Freud, 1914; Roussillion, 2010; Thanopulos, 2008). What can follow is a profound impairment in the capacity to relate to and depend on others, including the psychotherapist. When an individual manifestly expresses psychotic content, whether, for example, via delusional or paranoid or grandiose phenomena, they are actively showing us something of their internal world – the therapist is given something manifest to work with. But what are we to make of a psychotic patient who has fundamentally withdrawn, who is not expressing themselves directly? How do we as clinicians think about, relate to, and connect with someone who has very little if any libido to spare for the establishment of a therapeutic relationship and who creates the illusion of un-relatedness? I use the word "illusion" to echo Bion's (1957) assertion that the psychotically withdrawn patient never truly severs all contact with reality.

Results

Theme 1: the therapist's need for connection

It is unavoidable that the psychotherapist will have particular needs that they want to have met by their patient (Chused, 2012). If, however, the psychotic patient is withdrawn, this particular need of the therapist will be frustrated. What the therapist

does with their frustration in the face of withdrawal can potentially have a powerful impact on the treatment process.

Participant 3 reflected on her experiences of working with psychotic individuals who have with- drawn into their own worlds. She had this to say:

P3: "I think that my understanding of the psychosis is like a break in reality but it is also a break of interpersonal relating, because they are creating their own worlds and people and the outside world is no longer part of that so, for me, it is easy I think to switch off, to switch your mind off and say I am not even gonna follow that anymore."

Participant 3's statement reflects a particular understanding of psychosis – that it necessarily involves some form of withdrawal, and it illustrates that psychotic withdrawal can take many forms. The usefulness of the statement lies in how it illustrates the frustration of the needs of the therapist, and the therapist's subsequent inclination to withdraw. De Masi (2006, 2012) spoke of the psychotherapist's frustration and despair as they attempt to find a way to counteract the patient's defences and withdrawal in an attempt to establish some form of contact. Participant 7 gave his understanding of how psychotherapists respond to this dynamic:

P7: "They (therapists) don't feel connected, so they don't feel seen, they don't feel warm, they don't feel recognized, they feel overwhelmed with the despair. I guess many psychologists first study psychology, because they want to fix or to help, but even though they sit all day hearing other people's problems they want to feel special, because they're able to help them, and you have to be in a certain particular way to be able to sit with a patient and not seeing huge changes. You have to have a high frustration tolerance. You have to be able to tolerate again and again and again their demands, being forgotten about, or being dismissed, or not being recognized."

Lombardi (2005) echoed something of participant 7's understanding when he stated that contact with the psychotic condition can stimulate internal experiences in the therapist that are particularly laden with concreteness and intensity, so that achieving an eclipse of sensory and emotional phenomena (especially disintegration and hatred), and the consequent formation of a mental space, are precarious and difficult to navigate. Thus, the analytic process in these clinical situations is often deeply rooted in an a-symbolic and un-representable area, a potential burden on the therapist that is for the most part unconscious. When the patient withdraws from the world and from the therapist, it can further compound this dynamic, possibly leaving the therapist not just having to hold the disintegration and powerful fragmented projections, but also the uncertainty and despair that results from not being able to establish a relational dynamic with their patient (Lombardi, 2005). Sustaining this dynamic demands from the therapist adequate ego strength, which brings me to the next theme (De Masi, 2012; Thanopulos, 2008).

Theme 2: the therapist's ego strength

Part of what the psychotherapist does for the patient is to hold, contain and digest the difficulties that emerge in the therapeutic process, as well as sustain and survive challenging and frustrating processes. All this takes ego strength. When a psychotic patient withdraws and ceases to invest in the therapeutic process and in sharing the load the burden on the therapist can become too much to bear (De Masi, 2012; Thanopulos, 2008). Participant 2 had this to say about an experience of this dynamic:

P2.) "It feels too heavy, and it feels for me dead space, it feels for me, I like to have a move, um, the trudge through the heavy, and I'm not, in a strange way those cases become alive when they become floridly psychotic, because suddenly there is, there's interesting characters in the play, but in the other periods there's often for me this dead heaviness, a black hole, anti-matter".

During the interview with participant 5, a particularly challenging therapy of 9 years with a psychotic woman was discussed. The patient in question exhibited a profound withdrawal from the outside world:

P5.) "Well you see the thing is, she actually didn't talk, umm, it was very mad making, because, I used to wonder why she came, because she would, she graduated from the corner to the chair, but she still didn't really talk to me. She would sit quietly for sometimes the whole session, sometimes 99% of a session, and we would just sit. And I would sometimes make comments about, you know, whether I felt it was a bearable silence, or not a bearable silence, or, you know just comments to keep letting her know that I was there."

PSYCHOSIS 7 I asked participant 5 what they did to hold and sustain this challenging process:

P5: "Well, you know this is my . . . Well for me Bion is, he's just amazing, I think, because I didn't have a clue and I'd have lots of supervision and it ranged from things like 'confront her' umm, 'or interpret', to 'get her to draw', to nothing that I thought was particularly helpful . . . "

Participant 5 was referring to Bion's theory of Alpha function – the capacity to sit with and metabolize material that is not symbolically represented (Bion, 1957). It is interesting that the advice participant 5 received from colleagues was to do something. I speculate here that the supervisors' countertransference to the relational void in the therapy was difficult to bear, that they needed participant 5 to force movement in the therapy, to respond as though there was manifest content to work with.

The psychotic patient's capacity to relate can sustain significant damage as the available libido is turned inward on the self (Freeman, 1959). This could result in a lack of libido needed for the development of a transference relationship, rendering interpretations useless (Freeman, 1959). What potentially follows is a marked frustration of the therapist's needs to be acknowledged, allowed to be helpful, seen to be insightful or creative, or simply to engage. Participant 7 had this to say about what he believes it takes to manage this dynamic:

P7: "Umm, I believe you either got it or you don't, and that sounds not very thoughtful and very . . . but either you are able or you are not. To work with severe pathology. Many of our colleagues disregard many patients, because they don't have the capacity to attach, or so they are not suitable for psychotherapy and I believe that's a defence against engaging with somebody. Because they don't want to, or they don't like it."

The tendency to alter the reality of one's existence exists in the psyche of most human beings (De Masi, 2006). One of the goals of psychotherapy is to assist the patient in undoing the barriers between themselves and what they know on a fundamental level (De Masi, 2006). With a patient lost in psychotic withdrawal, one of the barriers is their inability to make contact with reality and with the therapist. It is as though they are hiding and believe that they are invisible. I believe it to be a frightful thing when the therapist plays along, "unable" to see the patient, as though they really have disappeared.

Theme 3: reviving relatedness

A withdrawn patient that seemingly cannot relate and a psychotherapist that tries to create the conditions that contribute to the establishing of relatedness potentially creates a situation that can demand a profound amount of patience from the therapist. Arieti (1966) maintained that one of the most fundamental aims of psychotherapy with someone who is psychotic is the establishment of relatedness, to make contact, to say, in a sense, "there you are, I see you". When the clinician does this and maintains this attitude despite the sustained absence of the patient's acknowledgement that they have been found, the conditions are created for some form of relatedness between therapist and patient to be revived.

Participant 5's patient, whom they saw for 9 years, did the following:

P5: "And that at the end of that year she left me a letter to say, in our break, just to say: 'I just want to thank you for being there for me'. So, umm, so even though you know, in terms of outwards connection, there didn't seem to be anything, I mean clearly there was something very profound happening." So it was "thank you for being there for me", oh! "And for going through this journey with me". And it made me think, my God, does she know what I've been holding for her?"

Here participant 5 expresses surprise at the level of connection that the patient feels, while simultaneously capturing the intense and burdensome nature of her longstanding attempts to try to nurture some form of connection with her patient. Thus, there appears to be some form of resolution, but perhaps it can only ever be partial.

Participant 1 provided another example of the revival of relatedness, placing emphasis on the fact that this is a slow process:

P1: "Because it's a lot of work doesn't feel like it can be short term that working with a psychotic patient is a long job, there is no other way. For example with patient X I saw him for 9 months and actually at the end, I used to use my wedding ring, and at the end he asked me if I was married, and I said, what do you think? And he said yes because of the ring and he said 'I hope he takes care of you', we were saying goodbye, and I thought that was really good, because he noticed you, he noticed another human being."

This example of a patient coming out of their psychic retreat illustrates what becomes possible when the therapist accepts the conditions and limitations inherent in establishing a therapeutic relation- ship with a psychotically withdrawn patient (Steiner, 1993).

Discussion

Psychotic patients who also exhibit withdrawal often leave behind the real world populated with its real objects. These patients may have very little libido to spend on investing in relationships, including the therapeutic relationship. This can make it very difficult for the psychotherapist to establish some form of relatedness with their patient. When the psychotic and withdrawn patient and the psychotherapist meet, there exists a potential for the creation of a seemingly a-relational space where the therapist is required to treat the patient "as if" they still retain the capacity to relate to revive the possibility of relatedness. In order for the therapy process to aid the patient in establishing a sense of self-experience and self-understanding, the patient needs to be able to acknowledge the existence of the therapist to some extent, as these experiences

are fostered within the context of relating (De Masi, 2006; Winnicott, 1971). This process, however, can become extremely challenging for the therapist, as was illustrated by the cited interview material. Some examples of therapists' responses to the psychotic barriers to relatedness include; "to switch your mind off ", to "feel disconnected and overwhelmed with despair", because of an experience where "there's often this dead heaviness, a black hole, anti-matter" which can result in a situation where "many of our colleagues disregard many patients, because they don't have the capacity to attach". In this paper I argue that, in the face of psychotic withdrawal, therapists are potentially at risk of refraining from working with these patients as a result of the subsequent frustration of their need to establish relatedness.

In a paper called "The Analytic Treatment of Schizophrenia", Albert Honig (1958) spoke to this dynamic, and to what happens when the therapist is willing and able to bear this relational difficulty. He proposed that, as the psychotic patient progresses to the extent of choosing an object in reality to gain from their oral libidinal desires, the symptoms of insanity often disappear (Honig, 1958). When the psychotherapist can allow for the frustrations involved in working with a patient lost in a psychotic withdrawal, they hold alive in their minds, and on behalf of the patient, the possibility of relating which becomes an often-crucial lifeline for the patient. In a sense, this scene is much like the therapist throwing a relational rope down a well to the patient below. The therapist needs to anchor their end of the rope until the patient is strong enough to find their grip, however long this might take.

Implications for further research

There exists a further need for the experiences of psychotherapists to be investigated to determine when and how the therapist's experiences of their patient's psychosis, and psychotic withdrawal in particular, shapes their understanding of the pathology and how it is to be treated.

Limitations

There are very few research studies on therapists' experiences of working with psychosis to use as a check, and so increasing the external validity of this study proved challenging. The exclusive focus on a psychoanalytic paradigm, as well as a relatively small sample size further limit the generalizability of the findings.

Strengths

As the number of studies that address the experiences of psychotherapists who work with psychosis is very limited, a research project of this nature is much needed.

Disclosure statement

No potential conflict of interest was reported by the author.

Paper 4: The Feared Therapist: On Being Part of the Psychotic Patient's Paranoid Delusion

Introduction

The final paper, like the first, is based on case material and explores my experiences of working with a particular psychotic phenomenon – a delusional and paranoid patient who has implicated the therapist in the delusional construction. I chose this particular focus as it demonstrates a phenomenon that captures multiple aspects that can make working with psychotic patients challenging for the therapist. It is also a phenomena that has received very little attention in the literature, particularly from experience-near accounts. In a sense, writing this paper and engaging with the available literature functioned as a supervision space where I could grapple with the concepts involved, and digest my disturbing experiences.

Paper

Abstract

Psychosis can be understood as, in part, a disorder of the self. The various factors that contribute to the development of psychosis and the consequences of psychotic symptoms potentially impede the development of the patient's subjectivity, and can lead to a complete breakdown of the patient's ability to accurately represent their subjective experiences. The development of paranoid delusions partially functions to compensate for the patient's inability to make sense of their subjective experiences in relation to an acknowledged other, in this case the psychotherapist. When the patient confronts the psychotherapist with their paranoid delusion and implicates the psychotherapist as a dangerous object, the psychotherapist is potentially exposed to a complex and disturbing dynamic where their own subjectivity may be drawn into question. This paper aims to explore the psychotherapist's experiences of this dynamic in a clinical setting by making use of a composite narrative of a psychotic patient with paranoid delusions that implicate the psychotherapist. The psychotherapist's experiences are discussed via the following three themes: Constructing the patient's subjectivity; The psychotherapist's use of their own experiences; and Holding the balance between opposing realities.

Key words: Psychosis, Countertransference, Psychotherapist, Delusion, Subjectivity

Introduction

Psychosis is, among many other things, a disorder of the self (Baumann, 2020). Individuals who suffer from psychosis frequently find themselves lacking a secure sense of their privacy, unity, autonomy, and control (Bauman, 2020). Working with psychosis typically confronts the therapist with evidence of the patient's fragmented sense of 'self' in relation to the 'other', and of the precarious primitive processes marred by the failures of unavailable, inconsistent, or overwhelming objects that have contributed to this fragmentation (Winnicott, 1971). This state is often characterized by anxieties that are unthinkable, what Winnicott (1971) called primitive agonies. Here the psychotherapist is often placed in a position where they are called on to look at some of the most ungraspable aspects of the patient's unconscious inscriptions, and to explore the early failures and injuries in the relationship between the care giver and infant that stand to disturb the primary processes of differentiation and subjectivation (Campoli, 2017). Moreover, the psychotherapist is also asked to hold and explore the often disturbing countertransferential reactions that this engagement can evoke (Saayman, 2017;2018;2019; Searles, 1966).

There are many ways in which a psychotic patient's fragmented self expresses itself in psychotherapy, albeit usually in a hidden manner. The patient's subjectivity - the person producing and experiencing the symptoms of psychosis - gets lost in the loudness of paranoia, hallucinations, and delusions. It can become difficult for the psychotherapist to find the patient's subjectivity under these circumstances, to notice and hold on to the frightened, confused, creative, and unique human sitting in front of them. This difficulty can be further compounded when the psychotherapist's own subjectivity is under attack. One particular phenomenon that can be encountered in patients suffering from psychosis is the presence of paranoid delusions where the psychotherapist is cast as a threatening individual. What I will provide in this paper is an attempt to look at three specific facets that I view as crucial to understanding and treating paranoid delusions when the psychotherapist is implicated in the delusion.

The first facet is the psychotic patient's frequent failure to represent their subjectivity in a manner that can be accessed by others. Whether via the idiosyncrasies in the manner in which these patients often make sense of things, or as a result of

hallucinations and delusions, or simply because of a profound disconnectedness from other people, individuals who suffer from psychosis can at times *seem* alien and alienating to others (Bollas, 2015). An individual suffering from psychosis is, in a sense, a subject (person) like any other, however the manner in which the psychotic individual's subjectivity is communicated may make it very difficult for the psychotherapist to construct and maintain their sense of the person sitting with them in the room, of the person's subjectivity (their internal structure, experiences, emotional states, beliefs, fears, wishes, and desires), which can lead to a disconnect and a failure to establish a relationship. The second facet is the psychotherapist's countertransferential experience of being the focus of the patient's paranoid delusion. How does this experience impact on the psychotherapist's sense of their own subjectivity? Lastly, the third facet is a matter of balance - when the psychotherapist is faced with a paranoid delusion which is directed at themselves, they are placed in a position where, among many other things, they have to simultaneously accommodate two very different realities – both the patient's reality as governed by the delusion, and their own. I will unpack these three facets and illustrate them via a reconstructed account based on clinical material.

Psychosis, paranoia, and delusion

A paranoid delusion can, to some extent, be understood as the patient's desperate solution to the problem of lacking a reliable manner of knowing whether their experience is rooted in fantasy, in their inner world, or whether it is part of the outer world, the world that the psychotherapist would consider to be *real* (Searles, 1966). It is important to hold in mind that paranoid delusions are in large part a consequence of the patient's internal emotional turmoil, and in particular the result of potentially unbearable fear (Kohut, 1977). In creating a delusional narrative, the patient may attempt to represent their paranoia and bind the anxiety (or terror), and account for what they experience, what is causing the experience, who is implicated in the experience, and how they can respond to render themselves safe.

One helpful way of elucidating the essence of the concept of delusion is to contrast it with the idea of fantasy. Fantasy, Oppenheim (2013) explained, is a function through which the individual can represent and understand the workings of their imagination, yet fantasy is also a product of imagination. Thus fantasy, a particular kind of

preconscious primary process ideation, remains accessible to the individual's consciousness which makes it possible for it to be impacted on by the secondary process (Oppenheim, 2013). Fantasy can be integrated into the ego in order to be used for integration of and mastery over the experiences of the self - communicable as language situated in the real, and as literature, art or music (Oppenheim, 2013). Delusion, on the other hand, differs in a fundamental way: it evades influence from the secondary process (Oppenheim, 2013). Where imagination can be used to repair the mind, delusion does the opposite, further solidifying and increasing the disturbing affects that it attempts to explain (Oppenheim, 2013). Delusion is a closed reality that is incapable of generating symbols (De Masi, 2015). Thus it does not invite the psychotherapist to reflect on its meaning or offer a contribution to its structure, which can, when the psychotherapist is implicated in the delusion, present the therapist with an anxiety-provoking claustrophobic experience that leaves them with little to no room to react in a generative manner (De Masi, 2015).

Paranoid delusions and disturbed subjectivity

Often, the psychotic process is a function of a failure in the development of the self (Liotti, 1999). The importance of including the phenomenon of subjectivity in thinking about and working with patients who suffer from psychosis is evident in psychoanalytic literature (Brazil, 1988; Brown, 2018; Gorney, 1978; Leader, 2011; Stephenson, 2018). 'Subjectivity' is a theoretical concept that has profound depth and complexity, as is illustrated in Mari Ruti's (2012) 'The Singularity of Being'. I will not unpack the complexities of subjectivity in this paper, but rather use the concept in the service of representing the 'self' and 'personhood' of the patient. In using the term 'subjectivity', I mean the following: Subjectivity, both in terms of the individual's experience of their *self* as well as how this is represented fundamentally exists relationally – within the sphere of the intersubjective (Garfield & Steinman, 2018). Regarding the function of subjectivity, I find Ogden's (1985) description both clear and useful:

> Subjectivity is a capacity for a gradient of degrees of self-awareness ranging from intentional self-reflection (a very late achievement) to the most subtle, unobtrusive sense of 'I-ness' by which experience is subtly endowed with the quality that one is thinking one's thoughts and feeling one's feelings as opposed to living in a state of reflexive reactivity. Subjectivity is related

> to, but not the same as, consciousness. The experience of consciousness (and unconsciousness) follows from the achievement of subjectivity. Subjectivity is a reflection of the differentiation of symbol, symbolized and interpreting subject. p.131

Throughout this paper I've used the terms 'subjectivity', 'identity', and 'self' interchangeably, and aimed to capture and convey one specific yet complex phenomena when doing so.

As a result of a fragmentation of their subjectivity, psychotic patient can literally become unable to speak themselves into being, to provide the therapist or themselves with an account of their subjectivity (Baumann, 2020; Brown, 2018; Gorney, 1978; Schwartz, 2009).). In this sense patients suffering from psychosis can be said to operate via a private idiosyncratic code (Brazil, 1988). Because delusions (as code) are usually characterized by rigid structures and symbolic poverty, the patient is often unable to reflect on or be creative with what their mind has produced (De Masi, 2015). The delusional construction is not to be used to help them make sense of themselves and of their experiences, and thus further distorts their sense of their own subjectivity (De Masi, 2015).

Paranoid delusions directed at the psychotherapist

It is often the case that psychotic patients would have been confronted with parents and significant others who have either responded to them in unclear and enigmatic ways that leave them confused about who they are, or who shocked them with jarring shifts as they changed their responses in unpredictable and contradictory ways (Searles, 1967). These experiences can make it very difficult for the patient to establish a clear sense of the reality of their experience of themselves, and of those around them (Searles, 1967). Many of the psychotic experiences that beset the patient can be understood as the result of the patient's efforts to manage a fundamental insecurity about the integrity and existence of their identity, what Kohut (1977) referred to as *disintegration anxiety* (Jakes, 2018). The psychosis is, in a sense, an attempt to cohere and protect a fragmented identity (Bollas, 2015). A delusional construct can be seen as a powerful tool aimed both at *trying* to make sense of disturbing and overwhelming experiences, and at protecting the *self*. Thus, the patient *needs* the delusion; often they can feel that their safety fundamentally

depends on it (Knafo & Selzer, 2015). This does not, however, imply that the patient's experience of a paranoid delusion is any less traumatic (De Masi, 2015).

Not all forms of psychosis are necessarily rooted in early developmental failures and traumas (Schafer, 2011). There are many factors that contribute to fractures in subjectivity, and the development of psychosis is a complex process made up of many parts (De Masi, 2015; Bollas, 2015; Jakes, 2018; Kohut, 1977; Schafer, 2011). I use this specific collection of theoretical understandings of psychosis as an example of an approach that aids the psychotherapist in establishing an awareness and understanding of the psychotic patient's subjectivity (Stephenson, 2018).

Given the proposed importance of the delusion for the patient, what is the psychotherapist to do when not only faced with the delusion, but also implicated in it (Knafo & Selzer, 2015)? If an attempt at relieving the patient of their delusion without resolving their need for it is understood as largely unproductive, the psychotherapist may feel unsure as to how they are to proceed – a disturbing kind of uncertainty that can dissuade psychotherapists from engaging with psychotic and delusional patients (Aronson, 1989'; Saayman, 2017;2018;2019). It has been well established in psychoanalytic theory that working with psychosis can be a confusing and disturbing experience for the psychotherapist (Bion, 1957; De Masi, 2009; Joannidis, 2013; Mills, 2017; Saayman, 2017;2018;2019; Schwartz & Summers, 2009). There are many psychoanalytic accounts of how and why psychotic communication is often represented and conceptualized as bizarre, disturbing, un-understandable, and seemingly devoid of meaning (Arieti, 1975; Benedetti, 1999; Bion, 1954;1975; Cain, 2010; Calamandrei, 2009; De Masi, 2009; Freud, 1924 Hill; 1955; Karon, 1992; Leader, 2011; Lucas, 2003; Olanen, 2009; Rosenfeld, 1969; Searles, 1963;1972;1973;1975; Winnicott, 1949). What I want to look at in this paper is how the psychotherapist might *experience* the strangeness that some psychotic individuals present them with - specifically the strangeness of being implicated in a paranoid delusion - and how these experiences potentially influence how the psychotherapist responds to the patient.

In the following sections I will use a composite case of a psychotic patient with a paranoid delusion that includes myself as a dangerous figure, to illustrate the

importance of the psychotherapist's use of their countertransference when working with a patient with a fractured subjectivity, doing so via three therapy sessions.

Case material

The case material presented here is a composite of a variety of psychotic and paranoid patients that I have worked with. This is a very vulnerable patient group, hence the notion of consent and its ethical implications need to be considered very carefully (Alfonso, 2002; Aron, 2016; Gabbard, 2000; Gabbard & Lester, 1995). Obtaining consent from these psychotic patients, as well as from the patients who I am not currently treating stands to be counterproductive to the therapeutic aims of their treatment, and potentially damaging to the therapeutic relationships (Aron, 2016). A composite case study combines aspects of a number of cases in such a manner that the resultant case contains material that would not be recognizable to patients themselves and would not allow any third party or other readers to recognize them (Alfonso, 2002; Willis, 2018;). Thus, the use of a composite narrative prevents any breaches of patient confidentiality (Willis, 2018).

Patient history

Leona is an Indian female in her mid-thirties. She was referred to me by a psychiatrist (Catherine) whom she saw in conjunction with another psychotherapist (Dianne). The long-term therapy that she had been in up to the time of being referred to myself had come to an abrupt end because Leona believed that the therapist's refusal to write her a letter of recommendation for Leona's application to a postgraduate study program was proof of the therapist conspiring against her. Leona's paranoid process was therefore in play from the beginning of her therapy with me, and it had a particular momentum by the time that we first met – echoing Freud's (1922) words that "the delusions which we regard as new formations when disease breaks out have already long been in existence" (p. 228).

All of the health-care professionals that made up Leona's treatment team work in a mental health clinic in the private sector. I saw Leona in my private practice rooms separate from the clinic.

Therapy material

Session 1:

Leona walked into my office and sat down on the couch. She looked at me and began speaking immediately, saying “I’ve been here before, last week. You drugged me and then abused me.” This statement threw me, and I found myself clarifying what she said. I asked whether our meeting felt familiar to her, and whether she was saying that this was not the first time we had met. Leona confirmed this, and said that we had met before, that I had drugged her. I asked, “the time before, you said last week, I drugged you, I took control away from you?” She explained that I exposed her to a type of gas that knocked her out. I asked her whether she thought that I was doing the same thing at that moment. She said no, that I wasn’t, but that others were involved, specifically Michael, her first psychotherapist, that he never admitted to drugging and abusing her, and that she was tired of people fucking with her. I did not have the presence of mind to ask her whether she thought that I was not admitting to having drugged her: I found it difficult to reclaim my capacity to think after the unexpected shock of being implicated in Leona’s delusional construction. I asked her what she thought I might have tried to accomplish by drugging and abusing her. Leona did not answer and moved away from this by saying that she did not know what Diana (her second psychotherapist whom she saw before myself) had told me, and asked whether I was aware of the letter of recommendation that she had asked the therapist for.

Session 19:

This excerpt is from a conversation that developed around thirty-minutes into the fifty-minute session. At this point Leona was talking about her mother in a calm and contained manner, despite recounting a disturbing experience. “My mother has never admitted to what she had done, and I remember it. I am the one who has to remember it. I am the one with the damage, the hurt.” I asked Leona whether she was speaking about a specific thing that happened. She said that she was, she explained that she had stolen wallets and used drugs, and that her parents had found out about the soldiers raiding the veterinary hospital where she worked. I asked her how they found out, and she stated that “things always come out, that they all know about it anyway.” She went on to say that it was the same as what happened with a previous psychologist: *they* discuss everything; *they* want to

embarrass her and fuck with her. At this point I wanted Leona to tell me more about her experience, but I felt muddled. There was a lot of content: the wallets, the drugs, the soldiers, and of course her mother. I did not reflect on how muddled it felt; instead I decided to focus on her mother, perhaps to meet my own need for clarity. I asked what her mother did when she found out about the wallets and the police, about the drugs. “She beat me, she hit me with a belt while I was getting dressed. She knocked me down and shouted at me, that this is what I deserve, that everybody knows what I had done. I told Leona that it sounded incredibly aggressive and frightening and asked her whether she was frightened at the time. In a disconnected manner she said ‘maybe’, but that it did not matter, that they all denied it. At this point I genuinely did not know whether what Leona said had truly happened, or whether it was part of her delusion. I asked Leona to help me understand what happened. Leona clarified, “she knocked me onto the floor of the room, got into it with me and pushed my face into the corner, into the floor, she pressed her knees into the back of my head”. At this point I wanted to know how real it was for Leona, and I said that it seemed like her mother was really angry, terrifying, that it sounded traumatizing to me. Leona did not connect with these notions of an emotional experience. She explained that her mother was also angry because Leona wore men’s underwear, and that her mother ignored her because of that. I asked when this happened - when did her mother hurt her? Leona frowned and said that she did not know when it happened, adding that her mother ignored her the previous year for wearing men’s underwear and for going to work with a beard. Again, I felt an urge to clarify. I told Leona that she was distinguishing between the two events and asked whether they felt separate. “Does what feel separate?”, Leona asked. I answered, “the time when your mother ignored you for wearing men’s underwear, and the time she attacked you in your room?” Leona looked at me and said, “She didn’t attack me, that’s a memory.” I asked her whether she was finding it difficult to tell the difference between a memory of something that happened to her, and a memory of something that she had thought about or imagined. “Yes” she answered, “I guess you can say that. I think it’s the delusions, the schizophrenia”.

Session 37:

Leona briskly walked into my office and sat down, staring at me intensely and angrily. I greeted her and said that she looked upset. Leona flew into a rage shouting

loudly, “Well what the *fuck* do you think, that I’m happy with all this, this this, this this bullshit, I’m fucking tired of this!” I asked her what she was referring to, what she meant by “this bullshit?” “*This*!” She waved a printed email at me, a copy of the letter from the Health Professions Counsel explaining why Leona was not entitled to receiving a letter of recommendation from her previous therapist. “They said I can’t have the letter and now that’s that. Ooooh, we can’t give the schizophrenic a letter because she is delusional!” She was still shouting. I nodded and could feel my own anxiety rising. Leona continued, “I am done with this, everybody wants to fuck with me because it’s easy. The schizophrenic is just making shit up! It’s Catherine (psychiatrist), it’s Dianne (previous therapist), its Michael (first therapist). Leona focused on me, gathered herself, and spoke in a calm but enraged voice, “And *you*, I don’t know what the fuck you are trying to do, last week you told me something, I can’t remember what it was, it doesn’t matter, but it was to see if you can also piss me off, it’s like one big fucking experiment, lets see how she reacts, and then we can just say she is delusional!” Leona was shouting again. I told her that I could see that she was incredibly angry. She picked up the glass in front of her. At this point I was not sure whether she might throw it at me. She screamed at the top of her lungs, “what do I have to do to get this to stop?! Do I need to hurt you, like I hurt my mother?! I beat the shit out of her because she pushed me too far!” At this point I did not feel anxiety, I felt fear. I felt my own fear and I felt Leona’s fear, heavily disguised underneath her palpable rage. I spoke to her calmly, but firmly, “Leona, you are protecting yourself now, you are angry because you feel unsafe and you don’t know who you can trust”. She responded angrily, “every fucking time, why, please explain to me why someone wants to do this!” I maintained my stance, unsure of whether it was going to work, unsure of whether I would be able to contain her or whether she was going to throw that glass at my head. “I understand that you are angry, it makes sense Leona, things feel really unsafe and I think you are afraid, you are scared of what might happen or what I might do. It must be terrifying for you to come in here and not be sure whether I am part of the people fucking with you.” She put the glass down and spoke in an angry tone, not shouting any more, “well not you, its Michael and Dianne and Catherine, and they know what they did!” My sense was that she was feeling less afraid of me in that moment, that she did not have to protect herself against me. Or was she backing down as a result of me standing firm? I felt my own relief as more space opened up for me to think. I was not being attacked in that

moment. I continued, “Leona you said it’s not me, are you saying you don’t feel like I am fucking with you.” She said no, that it was not me. I asked her whether she was experiencing something similar to what she had experienced in the past, whether she felt unsure whether what she thought might be real or not. Leona said that she did not know. I said that she felt angry and threatened, that she thought that I might have been fucking with her, possibly trying to abuse her, that it felt very real and very scary to her in that moment, and that she had to defend herself. Leona answered, “I don’t know, yes, perhaps”.

When the psychotherapist is implicated in the delusion

I compiled these three excerpts with the aim of demonstrating three facets that I deem necessary to consider when responding to paranoid delusions that are directed at the psychotherapist: An awareness of and sensitivity to the psychotic patient’s disturbed subjectivity; the psychotherapist’s experience of this phenomenon, specifically in terms of how the experience stands to impact on the treatment; and the psychotherapist’s attempt to find and hold a balance between two different realities.

Constructing the patient’s subjectivity

When a paranoid and delusional patient is at a loss for “reliable organizing principles to render meaningful and manageable the chaotic perceptions that assail them”, they are in desperate need of the psychotherapist to hold their powerful projections without losing sight of their subjectivity (Searles, 1966 p.6). In our first meeting, Leona began the session by saying that she had visited my practice previously, and that I had drugged and abused her. This statement caught me off-guard. I had no internal representation of the person who was saying this to me, no sense of her subjectivity – not only because this was our first meeting, but as a result of Leona’s inability to represent her subjectivity. I was tasked with responding to being cast in her delusional construction without knowing *who* I had supposedly subjugated, without a sense of the *person* who was experiencing the danger, emotional turmoil, and confusion (Anscombe, 1981; Bacal, 2016; Searles, 1967)? Further complicating the matter was the fact that Leona could not recognize this. Her need was to draw on a delusional narrative to explain where she was, who I was, what my intentions were toward her, and why she was feeling disturbed (De Masi, 2015; Searles, 1967). In

other words, she did not arrive with the intention or ability of finding out who I was, or of helping me to get to know her. My own subjectivity was subjugated (Yerushalmi, 2018).

It took me a fair amount of time to orient myself to Leona and to begin the process of attempting to construct a representation of her subjectivity via my own disturbed subjectivity. There is, however, no guarantee that when attempting to represent the subjectivity of a paranoid and delusional patient, the patient will obviously respond and relate to the psychotherapist's mirroring (Bollas, 2015; Searles, 1967). In session 19, when Leona was describing how her mother had brutalized her, I responded by saying that it seemed like her mother was really angry, terrifying, that it sounded traumatizing to me. It did not appear to resonate with Leona that she may have had a disturbing emotional reaction to what she believed had happened. However, regardless of her seeming inability to connect with the possibility of feeling something powerful, I was beginning to imagine her subjective experience and represent it to her (Anscombe, 1981). The aim of these reflections was, in part, to help Leona to construct the reality that she *has* feelings, and that these feelings can be noticed and seen as significant by someone else. This construction is what Searles (1967) called the *feeling image* of the patient. In constructing the patient's subjectivity via a feeling image, the psychotherapist holds the patient's self in their own mind, presenting it to the patient at the appropriate time in a manner that does not engulf the patient's thinking (Searles, 1967).

I had numerous experiences with Leona where I tried to represent her subjectivity to her without her giving me any clues as to whether she found this helpful or not. This left me feeling anxious about whether what I was doing was helpful and theoretically sound, I kept going back to the literature to confirm that I was on the right track – a kind of substitute for Leona's seeming lack of subjective responses, as well as a way to maintain my own subjectivity as "the therapist who can still think, and who is helpful, not abusive". Was I here, rather than trying to re-find my own subjectivity via the disturbance, compensating for its lack by turning to theories and hypotheses in a manner that mirrored something of Leona's need for delusions to compensate for her own lack of subjectivity? The psychotherapist's subjectivity makes up an important component of the therapeutic process and the understanding of countertransference

(Kernberg, 2016; Long, 2015). My engagement with Leona was typified by a lack of the reciprocal acknowledgment of my and her respective subjectivities, and it often left me feeling like I had to respond to complicated psychopathology without a familiar sense of myself. What made the experience of being implicated in Leona's delusion particularly difficult for me was the fact that it subjugated my subjectivity, the place from where I might respond to her (Yerushalmi, 2018). Importantly, this countertransferential experience mirrored something important about Leona's experiences of her own subjectivity coming under threat.

The psychotherapist's use of their own experience

The psychoanalytic psychotherapist's clinical application of their own countertransference makes up a crucial part of psychotherapy (Lee, 2017; Long, 2015). It in part enables the psychotherapist to (attempt to) hold on to their own mind as they track what happens inside of themselves via a (hopefully) established capacity and willingness to be at times deeply disturbed (Jakes, 2018). Furthermore, the psychotherapist's deep and nuanced awareness of how they experience their psychotic patient and what the patient brings into therapy forms part of the structuring of a coherent representation of the patient, made up of all the fragmented self-experiences, undifferentiated part-objects, confusion and pain that the patient fails to cohere on their own (Jakes, 2018; Lee, 2017).

Psychoanalytic psychotherapy is dependent on a form of communication that is mutually subjective (Green, 2000). Green (2000) highlighted how this facet can be obfuscated when the therapist listens to the patient's narrative in a manner that is detached from the subjectivity of the patient. "The message is examined as if from outside. This is the typical distancing that prevents the analyst from being emotionally overwhelmed by the patient's discourse, this distancing offers the optimal vision of what must be analyzed (p.60)." Green (2000) called this approach to listening the *objectivation of subjectivity*. The psychotherapist can potentially use an objective stance defensively in a manner that not only bypasses their own experiences and subjective views, but also the experiences and subjective views of the patient.

In my first session with Leona, rather than asking her what it was like for her to be in a room with someone who she believed drugged and abused her, I asked her what she thought I may have wanted to achieve through those acts. I needed my own uncertainty and confusion to be resolved at the cost of representing Leona's experience. In a similar sense, I experienced our focus on the letter of recommendation as a relief from the confusion and disturbance that I felt when she claimed that she had been in my office before, and that I had drugged and abused her. My willingness to move away from the delusional discourse can be viewed as an objectification of Leona's subjectivity. The focus on the letter allowed for my own subjectivity to remain intact, I was the therapist discussing the letter, rather than the therapist who was confused.

Aronson (1989) explained that "the paranoid's use of aggression is usually defensive in the sense of responding to potential narcissistic injuries by outside malevolent forces; in its extreme, it may take the form of narcissistic rage, a desire for revenge" (p.344). In session 37 I experienced Leona's rage, it evoked powerful and disturbing anxiety in me (will I be able to contain her?), fear (what if she throws the glass at me?), and destabilizing doubts that made it difficult for me to stay with what she was feeling (did I cause her fear and rage, was I dangerous?). This unsettling experience was further compounded by my sense that I was not going to be able to reason or negotiate with Leona around the reality and truthfulness of what she was saying. This sense speaks to the notion that, in cases of delusion, the principle of non-contradiction ceases to apply (De Masi, 2015). In other words, pointing out the flaws and inconsistencies in what Leona was saying would likely have had little enlightening effect on her, she was operating from a position of psychotic logic (De Masi, 2015). The primary danger in this manner of thinking is that anything can be true - if it can be thought, it can exist. As a result, distinctions between improbability, probability, possibility, impossibility, fantasy and reality are lost in the warped logic of the delusional system (De Masi, 2015). This implies that, when confronted with an uncontained delusional patient, the psychotherapist has to rely much less on their capacity to reason with the patient, and much more on their capacity to hold the patient's projections, and importantly, the capacity to hold and regulate their *own* experience of disturbance (Saayman, 2017;2018;2019). This is what I attempted to do with Leona when she was enraged and terrified in session 37: I allowed myself to

experience the full force of her presence as well as the subsequent disturbance that it evoked in me. This was not an easy task. Tolerating (rather than understanding) my own countertransference felt deeply unsettling, as I was continually threatened by primitive anxieties around identity loss (McCarthy, 2004). These experiences were, however, useful in that they guided me back towards the relational experience between Leona and myself, and to a clearer sense of her subjectivity and how it might be represented (Dauphin, 2017).

Holding the balance between opposing realities

Establishing an intense relationship with a deeply disturbed patient can steer the psychotherapist toward an uncomfortable interrogation of what would be considered an appropriate theoretical stance and acceptable technique (Gorney, 1978). When attempting to find a theoretically sound technique when engaging complicated psychopathology, it is crucial that the psychotherapist continually interrogates their own needs. I attempted to do this in my work with Leona. To what extent was I trying to be useful to her, and to what extent was I trying to maintain my own subjectivity, specifically in terms of my own need to experience control, competence, and certainty (Renn, 2018)? I often found myself needing to answer questions about technique: When a patient is trapped in a psychotic state, to what extent does the psychotherapist interpret the paranoid delusional patient's experience of the therapist-as-dangerous as a transferential phenomenon? An interpretation that links the patient's earlier experience, their internal world, and who they experience the psychotherapist to be, may in some instances be rooted in the assumption that the patient has *chosen* the psychotherapist as container for their projections (Mills, 2017). It is a very human thing to project desires, fears, conflicts, and wishes onto the objects in the external world (Bion, 1957; Mills, 2017). However, psychotic patients can at times fail to reserve their projections for specific objects, sending them off at random as a result of a breakdown in their ability to accurately track the objective conditions in their surroundings – a form of failure in ego function (Bion, 1957; Mills, 2017). Simply put, the immediacy of experience can become too much, and the patient can lose track of the differentiation between threats that exist in reality and threats that exist in fantasy (Mills, 2017).

Another matter is the extent to which the therapist uses reality testing with a psychotic patient. One of the potential risks inherent in using reality testing to help the patient to distinguish between what is real and what is not lies in the possibility that the patient is further confronted with the idea that they cannot trust their own mind at a time when they feel profoundly vulnerable and threatened, which could heighten the patient's fear and confusion (Aronson, 1989). Then again, engaging the fact that the patient cannot trust their own mind could very well be precisely what is needed.

The use of interpretations with a psychotic patient, specifically a delusional and paranoid patient stands to potentially leave the patient feeling blamed for or further victimized by their internal process (Aronson, 1989). An interpretive approach also presupposes that the patient has the capacity to differentiate between past and present experiences, as well as the ability to reflect on how the convergence of these experiences represent their internal world – capacities and abilities that are usually absent in a patient who is psychotic and delusional (Bion, 1957). Rather, an approach that is supportive and explanatory holds more potential value for the patient (Aronson 1989). Establishing a level of safety and trust amidst the intensity of the patient's paranoid delusion directed at the psychotherapist potentially lays the foundation for later exploration of possible transferential links between the patient's experiences of the psychotherapist as unsafe and earlier object experiences (Aronson, 1989).

The psychotherapist's disturbances can be used to make sense of the patient, to find a way to relate to them (Long, 2015). In line with this, in session 37, I attempted to empathically join with Leona in her experience of fear and rage by validating her anger and her experience of threat, rather than interpreting what she said. I did this in an attempt to accept and hold her experience, while trying to render her experience representable and thus thinkable and linking it to her subjectivity. While speaking to Leona's subjectivity and her experiences of fear and anxiety, I was implicitly giving representation to my own subjective experiences. If the psychotherapist is willing to sit with the ambivalence of holding the validity and importance of two very different realities, and attempt to find their patient's emotional experience in the storm of the delusion via their own subjective experience, they

create for the patient an experience of their very *self* being worthy of being received (Bollas, 2015).

Conclusion

Basic questions about what it means to be human and to have subjectivity come to the fore when the psychotherapist engages with psychosis (Anscombe, 1981). When an individual suffering from psychosis asks for the psychotherapist's help, they are likely to reveal their ontological fragility, their precarious subjectivity (Gherovici, Steinkoler, & Bonnigal-Katz, 2018). This task can require the psychotherapist to engage with their own countertransferential disturbances in a manner that may be frightening, unsettling, and at times overwhelming. As a potential result of the psychotic patient's fractured subjectivity, the psychotherapist's subjectivity can be eclipsed, at times making it very difficult for the therapist to track their own experiences and responses in the therapeutic setting (Kernberg, 2016). Without some form of representation of the psychotherapist's subjectivity the patient cannot begin to determine how to relate to the therapist, and what affective states the therapist will be willing and able to tolerate (Ivey, 2013). One way in which a psychotic patient can solve this dilemma is by determining the psychotherapist's subjectivity via their role in a delusional construction. The psychotherapist, confronted with what is essentially an obliteration of their subjectivity, can in these instances be thrown into situations where they have to tolerate high levels of anxiety and discomfort, while trying to construct a preliminary version of the patient's subjectivity (Brazil, 1988; Searles, 1967; Yerushalmi, 2018). In these instances, the possibility exists that the psychotherapist may hold the patient responsible for the negation of their subjectivity, providing the therapist with what might be viewed as a reasonable alibi for disengaging from a disturbing experience (Ivey, 2013). Yet engaging with disturbance is, to a large extent, the psychoanalytic task; for the psychotherapist to follow their patient's projections however deep they may penetrate, to hold and render thinkable the resultant disturbance, to separate out their own disturbance from that of their patient, and to give back to the patient an understanding that can be used to construct and validate the patient's subjectivity, perhaps for the very first time (Brazil, 1988; De Masi, 2015; Kernberg, 2016; Long, 2015).

Discussion

Introduction

The aim of this study was to explore the experiences of psychoanalytic psychotherapists who work with psychotic patients. The study focused specifically on psychotherapists' countertransferential experiences. Psychoanalytic psychotherapists were invited to participate in interviews about their experiences, thoughts, and feelings regarding their work with psychotic patients. I have also used case-study material from my own psychotherapeutic work with psychotic patients. Very little research has been done on this topic, and so the aim of this study was to expand on the existing literature that captures experience-near accounts of psychotherapists' reflections on their clinical work with psychotic patients. The aim of this chapter is to provide a succinct overview of the primary findings of this study by pulling together the standalone papers and linking the findings to the relevant psychoanalytic literature on the treatment of psychosis. Each of the four standalone papers focused on specific aspects of the psychotherapist's experiences of working with psychosis. In the following section each paper will be briefly introduced, and then discussed in relation to the original research questions. Attention then turns to the limitations of the study and suggestions for further research.

The Four Papers

Paper one - Flying Blind in the Psychotic Storm.

The first paper presents a case study of my therapeutic work with a psychotic patient in an inpatient setting. Drawing on a series of therapeutic encounters over a 6-month period, the paper presents an experience-near account of the countertransferential impact of working with a psychotic patient. The paper raises the issue of how the psychotherapist's experiences of the patient's psychosis affect their capacity to receive, think about, and process the patient's communications and projections. Focus is given to the blurring of sanity and madness in the use of language during therapy, in the psychotic transference and therapeutic relationship, and in the dreamlike quality of the interaction. This reflective analysis leads to the conclusion that the psychotherapist can experience self-reflective failure which can potentially lead to impasse, but can also lead to the restoration of relatedness.

The paper engages the phenomenon of the psychotherapist's disturbing countertransference experience of working with psychosis and the significant impact of this experience on the

therapeutic process. De Masi (2015; 2009) asserted that many mental-healthcare professionals will experience their therapeutic engagement with psychosis as confusing and indeterminate. In line with this assertion this paper claims that the psychotherapist's experience of confusion and distress can evoke a powerful need to regain a sense of control through an intellectual understanding of the patient rather than an attempt at relating. This dynamic can also motivate psychotherapists to avoid working with psychotic patients altogether, echoing Searles' (1967a) view that the therapist will in no other situation be faced with so brutal a confrontation with his or her most primitive anxieties, and fears of disintegration.

The paper goes on to assert that the psychotherapist's experience of the therapeutic relationship will likely be influenced by psychotic transference, the patient's approach to boundary management, and the extent to which the psychotherapist is able and willing to receive psychotic projections. The importance of the therapeutic relationship in managing these potential difficulties is highlighted, as the relationship functions as container within which the interactional disturbances can be experienced and negotiated. The notion that, when working with psychosis the psychotherapist needs to engage with their own unsettling countertransference experiences in order to truly connect with the patient as put forward by Kernberg (2003), is confirmed by the findings of the paper.

Overall paper 1 suggests that the overt and perplexing presence of the patient's unconscious in psychotic communication demands of the psychotherapist a stance that allows for a fluidity between symbolic and literal representation, as supported by the writing of Freud (1900) and Bion, (1954). Based on the work of Ogden (2007), the idea of 'talking as dreaming' is put forward as a concept that can be used by the psychotherapist to alter the manner in which they listen to psychotic communication in the service of enabling a shift in listening to accommodate different registers of communication.

Paper two - Psychoanalytic Psychotherapists' Experiences of Disturbance in Response to Working with Psychosis.

The second paper is based on the interviews with psychoanalytic psychotherapists. This paper focuses on unsettling and challenging experiences for psychotherapists in their work with psychotic patients. The effects of the therapeutic process on the psychotherapist's mind, on their reality testing, and on their capacity to think is explored, as well as the impact on the psychotherapist's body and somatic experience.

The results reported on in this paper support the hypothesis that psychotherapeutic work with psychotic patients can be deeply disturbing for the psychotherapist, and that these experiences of disturbance can deter psychotherapists from engaging with psychotic patients. These findings are in line with the literature that speaks to these kinds of disturbances and suggest that there is long-standing resistance to engaging psychotherapeutically with psychosis (De Masi, 2009; Kongara, Douglas, Martindale, 2017; Martindale, & Summers, 2017). Searles (1963, 1973) posited that psychotic patients can use projection, desire, and physical proximity to encroach on the psychotherapist's boundaries, often as a result of the patient's lack of awareness of their own physical and psychological boundaries. This study has found that these dynamics can evoke extreme discomfort for the psychotherapist, and that it can give rise to the psychotherapist experiencing an urgent instinctive pressure to escape, either through emotional and relational disconnect or via a distortion of the psychotherapist's own sensory experiences.

Di Rocco & Ravit (2015) stated that psychotherapists who engage in work with psychotic patients need to be able to survive contact with psychotherapeutic dynamics that feel threatening, as well as with their own introjects and archaic structuring experiences – an engagement dissociated from logical thought that will undoubtedly influence the capacity to test reality and track patients. The experiences of psychotherapists presented in this paper are in line with this notion, emphasising the potential for the therapist to become overwhelmed, as well as the importance of the development of the therapist's ego strength (Mirvis, 2017).

The paper also explores psychotherapists' bodily experiences in their work with psychotic patients, and argues that experiences of extreme fatigue, disgust, and hunger could be the consequences of the effects of the patient's unsymbolized projections. Gubb (2014) amongst others, have explored the importance of somatic experiences for psychotherapists; this paper suggests that bodily experiences help to understand the experience of psychosis. This notion is echoed by Lombardi, Genovisi, & Isgro (2020), and in this paper, is predicated on the psychoanalytic idea that the roots of psychosis often lie in the early years of life when the human experience of pain and pleasure manifested as unsymbolized and bodily (Bion, 1956; Conway & Ginkell, 2014; Freud, 1924; Klein, 1935).

Paper 2 concludes with the argument that the disturbances experienced by the psychotherapists are not examples of failures. In line with Bollas (2015, 1983), these experiences that can confront the psychotherapist with their own capacity for madness, are understood as necessary aspects of the psychotherapeutic process with psychotic patients.

Paper 3 - Psychotherapists' Experiences of Withdrawn Psychotic Patients

The third paper continues the analysis of interview material by focusing specifically on how psychotherapists experience and respond to psychotic patients who are unable and frequently too afraid to connect with the world outside of them. The paper explores the frustrations of work with withdrawn patients in light of the strong need therapists often have to connect with their patients. The paper considers how therapists found their way through this frustration by drawing on their own ego strength to tolerate disconnection. An analysis is offered of some moving instances where therapists were able to revive relatedness between themselves and their patients. The paper concludes by highlighting the extreme challenges posed for therapists who then run the risk of evading connection by avoiding. Paradoxically, however, the ability to tolerate disconnectedness can lead to important therapeutic moments of connection between patient and therapist.

One of the primary features of psychosis is some form of breakdown in the patient's capacity to relate, which frequently leads to relational withdrawal (Arieti, 1966; Bleger, 1974; Cullberg, 2006; De Masi, 2012, 2017, 2020; De Masi, Davalli, Giustino, & Pergami, 2015; Green, 2012; Knafo, 2020; Roussillion, 2010; Steiner, 1993).The findings of this paper correspond to De Masi's (2006, 2012) assertion that psychotherapists may experience working with psychotic and withdrawn patients as extremely challenging. The paper goes on to illustrate that therapists may respond to the patient's act of withdrawal by disconnecting from the process of relating as a defence against the fear and despair that a fundamental disconnect from the world can evoke (De Masi, 2006, 2012). In line with Chused, (2012), the paper demonstrates that one of the factors that can contribute to the psychotherapist's challenging experience is their own unmet need for relatedness when working with a psychotic and withdrawn patient. In line with the views of De Masi (2012) and Thanopulos (2008), the paper goes on to make the argument that a withdrawn psychotic patient can also frustrate the psychotherapist's needs to experience themselves as effective, helpful, and appreciated which can evoke strong insecurities for the therapist. This dynamic can result in the therapist viewing the patient as unsuited for psychotherapy as a way of maintaining the integrity of their own sense of professional competence (De Masi, 2012; Thanopolus, 2008).

The paper concludes by discussing the importance of the psychotherapist's ego strength as a resource to draw on during prolonged and disturbing times of relational disconnect with psychotic and withdrawn patients. The point is made that when the psychotherapist is able to

maintain the possibility of relating, a space is created within which the patient can begin to make contact.

Paper 4 - The Feared Therapist: On Becoming Part of the Psychotic Patient's Paranoid Delusion.

The fourth and final paper draws on a composite case derived from my clinical experiences with a number of psychotic and paranoid patients. It specifically explores the situation in which the psychotherapist becomes implicated in the patient's delusion as a malignant object and reviews the challenges that can potentially develop as a result. The composite case illustrates the dilemma created when a therapist confronts a patient's fractured subjectivity and is required to imaginatively construct their subjectivity from the therapist's alternative experience of reality. The importance of harnessing the disturbing countertransference is discussed, as well as the importance of holding the balance between two opposing experiences of reality (that of the therapist and that of the patient). These processes help not only the therapist but also the patient to navigate the patient's frightening experience of being attacked by the therapist.

The importance and function of a delusion for the patient has been well represented in psychoanalytic literature (De Masi, 2015; Galiani & Napolitano, 2020; Jakes, 2018; Knafo & Selzer, 2015; Searles, 1967; Solano, & Quagelli, 2019). However, very little has been written on how psychoanalytic psychotherapists are to navigate being implicated in their psychotic patient's paranoid delusion. Paper 4 positions the notion of *subjectivity* as a key concept when working with paranoid and delusional psychotic patients and makes the argument that it is both the subjectivity of the patient as well as that of the psychotherapist that comes under threat when the psychotherapist is implicated in the patient's paranoid delusion (Brown, 2018; Searles, 1967). The paper provides a structured approach to responding to paranoid delusions that implicate the psychotherapist, and presents the value of constructing the patient's subjectivity by illustrating how it can enable the psychotherapist to speak to the patient's subjective experience rather than attempting to address the validity of the delusion (De Masi, 2015; Searles, 1967). This implies that, when confronted with an uncontained delusional patient, the psychotherapist has to rely much less on their capacity to reason with the patient, and much more on their capacity to hold the patient's projections and hold and regulate their *own* experience of disturbance (Saayman, 2017;2018;2019).

The paper explores the psychotherapist's stance in relation to the dichotomy between their own reality and the alternative reality of the patient as represented by the paranoid delusion. Gorney (1978) stated that psychotherapists may experience intense doubt about their theoretical position and competence when working with very disturbed patients. For the psychotherapist facing this confusing situation, the paper suggests that the psychotherapist needs to view their own subjective distress and confusion as part of the countertransferential response to being implicated in a paranoid delusion. The paper makes the argument that, when the psychotherapist's subjectivity comes under threat, primitive anxieties around identity loss can potentially overwhelm the psychotherapist (McCarthy, 2004; Yerushalmi, 2018). Echoing the positions of Kernberg (2016) and Long (2015) and others, these disturbing experiences are presented as useful countertransference experiences that, when held and understood, can help the psychotherapist to create a deeper sense of the patient's fear, uncertainty, and need for control (Garfield & Steinman, 2018; Lee, 2017).

Limitations of the study

The methodological limitations of this research have been discussed in Chapter Two. The research done in this thesis is based on case studies from my own work with psychotic patients, and on the interview material obtained from eight psychoanalytic psychotherapists. The adequacy of the sample size can be drawn into question when issues such as generalizability and transferability are considered. However, the nature of the phenomena explored, specifically the countertransference experiences of psychotherapists, legitimize the sample size as the purpose of the study was to investigate particular experiences that psychotherapists may have when working with psychosis, rather than testing to what extent all psychotherapists do in fact have these experiences. A sample size of eight psychotherapists proved adequate to reach saturation based on the interview schedule. Further research that builds on psychotherapists' countertransferential experiences of working with psychosis is indicated, as this study suggests that these experiences hold the potential to influence how psychotherapists think about and engage with patients who suffer from psychosis. Building on this, there is a need for further research that aims to position psychotherapists' countertransferential experiences of working with psychosis as a means of further developing and optimising the psychotherapeutic treatment of this patient group, rather than using the difficulties encountered in furthering the narrative that these patients are not suited for psychotherapy.

Inherent in the use of psychoanalytic case studies is the possibility of the researcher being seduced by the material (Tuckett, 1993; Widlocher, 1994). Specifically, my own position as researcher can be a point of criticism, as I have inhabited multiple roles throughout the engagement – that of researcher, psychotherapist, and advocate. Complete separation of these roles has proven impossible, and each role has likely impacted on the other in various ways. I have endeavoured to remain mindful of this, and have relied on feedback from my research supervisor in order to claim and manage any overlaps and the possible resulting biases. The publishing process has also proved helpful in this regard, as the readers whom I engaged with via each of the four review processes held me to a very high standard of research.

Throughout this research I have used specific definitions of terms like 'psychosis', 'countertransference', 'subjectivity', 'delusion', and 'relating'. This was done in the service of being very clear about the meaning of the terms used. However, the specific selection of certain definitions over others holds the potential to omit valuable alternative understandings of the concepts studied from the research process. This potential has been held in mind, and I have remained aware of the fact that this thesis views the concepts studied through a particular psychoanalytic lens.

Directions for future research

This study has illustrated the importance of countertransference-based research, as well as the lack of this category of research in relation to psychoanalytic psychotherapy and psychosis. Further research that builds on psychotherapists' countertransferential experiences of working with psychosis is indicated, as this study suggests that these experiences hold the potential to influence how psychotherapists think about and engage with patients who suffer from psychosis. Building on this, there is a need for further research that aims to position psychotherapists' countertransferential experiences of working with psychosis as a means of further developing and optimising the psychotherapeutic treatment of this patient group, rather than using the difficulties encountered in furthering the narrative that these patients are not suited for psychotherapy. Research that investigates psychotherapists' experiences of bodily phenomena in relation to psychotic patients holds the potential to contribute to psychoanalytic notions of what psychotic projections are, and how they can potentially influence the psychotherapist's somatic experiences. The role of the therapeutic relationship has been

positioned as crucial in this study, and warrants further research on how psychoanalytic psychotherapists experience and manage severely disconnected and withdrawn psychotic patients. One can make the case that it is perhaps necessary to problematise the idea that countertransference is traditionally understood and explored within the context of what would be considered a mutually recognised and experienced relationship between psychotherapist and patient. The false notion that the psychotherapist's lack of experience of relational connection with their psychotic patient illustrates the lack of therapeutic process and transferential exchange warrants further exploration of how psychoanalytic psychotherapists make sense of the processes and aims of psychoanalytic therapy with psychotic patients. Lastly, the sample size of this study represents the experiences of nine psychotherapists. Further research on the themes covered by this study that includes more psychoanalytic psychotherapists from various treatment milieus, countries, and psychoanalytic schools of thought can further the exploration of the relationships between psychoanalytic notions on the treatment of psychosis and what psychotherapists actually experience.

Conclusion

Freud (1924a) explained that the development of a therapeutic relationship with a psychotic patient is unlikely due to the lack of a transference relationship. He attributed this to the patient's unresolved primary narcissism, and to their subsequent inability to form meaningful object relationships (Freud, 1924a; Klein; 1946). Freud (1924a) did not, however, deny the psychotic patient's attempt to re-establish some form of relationship with reality, although he indicated that this attempt serves the reparation of a loss - the dressing of a wound - rather than the reestablishment of relationships. It is clear from both the literature and the results of this study that it can be incredibly difficult for the psychotherapist to establish a relationship with a psychotic patient. Yet this is the single most important part of the treatment, as the creation of some form of meaningful relating between a therapist and a patient suffering from psychosis is often the very treatment itself (Schwartz & Summers, 2009). I am not making the argument that all clinicians should be willing and able to work with psychotic patients. What is needed is that all clinicians honestly claim their own preferences and limitations, and that those who cannot or do not want to work with psychotic patients frame it thus, rather than saying that these patients are not suited for psychotherapy. This would mean, however, that all clinicians engage with their own internal limitations, defenses, wounds, and desires – a difficult and at times

impossible task. This is not a novel idea; it is, in a sense, what a clinician signs up for when they decide to practice psychoanalytic psychotherapy. Psychoanalytic psychotherapy necessarily includes the psychotherapist's engagement with their own countertransference (Bion, 1954; Lee, 2017; Long, 2015). It could be said that the psychotherapist's honest engagement with their countertransference renders psychoanalytic psychotherapy an ethical act. Psychosis has, in a sense, been misunderstood by many psychoanalytic practitioners – as the extreme psychopathology that confounds the psychoanalytic method. Herein lies a great loss, for, far from confounding it, an engagement with psychosis may reveal the incredible potential of the psychoanalytic method to capture profound suffering and pain in deep, nuanced, and at times, disturbing ways. Furthermore, working with psychosis highlights what the psychoanalytic method can reveal about the psychotherapist's own fragility, desires, imagination, and strength. When the psychotherapist can allow for this, and even find meaning, growth, and enjoyment in it, they can find themselves in a space where their experience of humanity is most raw and most profound.

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Appendix 1

Interview participants information letter & consent forms

Information letter

Dear potential research participant.

I am a clinical psychologist in private practice, and am currently enrolled for a doctorate at the University of the Witwatersrand. My research aims to better understand the experiences of psychoanalytically-orientated psychologists working therapeutically with psychotic patients. The research will involve interviews that will be digitally recorded and transcribed.

If you are a psychoanalytically-orientated psychologist who has experience of working therapeutically with psychotic patients, I would like to invite you to participate in the study. The aims of the study will be to try to get a sense of what your experiences of working with psychotic patients have been, and how you understand these experiences. The study will be based on a semi-structured interview that will take between one and one-and-a-half hours to complete. The interview will be scheduled at a time that is convenient for both of us. Depending on the results of the initial interview, follow-up interviews may be requested, and conducted with your permission, and at your convenience. With your permission the interview will be digitally recorded and transcribed verbatim. The recorded and transcribed information will be stored on password-protected computer, and only my supervisor (Prof. Carol Long) and myself will have access to the data. All of your identifying information will be handled with respect and sensitivity to ensure confidentiality in the final report. Thus a pseudonym will be used throughout (unless otherwise specifically requested), as direct quotes will be included in published aspects of the work. The aim of this study is to explore your therapeutic experiences of working with psychosis, and not to evaluate or critique your way of thinking about psychosis or your methods of intervention. No preparation for this interview will be necessary.

There are no foreseen risks involved in participating in this study. There are also no foreseen direct benefits, although involvement in this study could contribute to a more general psychoanalytic understanding of how working with psychosis effects therapists. It is foreseeable that case material might be discussed during the interviews. If this happens I would like to request that you omit identifying patient information. I will also take care to exclude any identifying information of patients in the final report, and will treat the case material with the utmost sensitivity and respect.

As participation is voluntary, there will be no negative repercussion should you feel uncomfortable answering any of the questions, or decide to withdraw from the study at any point. The results of this study stand to form part of internationally and locally published articles, which form part of the criteria for completion of the PhD. Upon your request, a summary of the results will be sent to you once the research is complete.

Please feel free to contact me or my research supervisor (Prof Carol Long) should you have questions or concerns.

Sincerely

Nardus Saayman

TEL: 0834105408

EMAIL: nardus@parkviewtherapist.co.za

SUPERVISOR: Prof Carol Long (TEL 0117174510 / EMAIL carol.long@wits.ac.za)

Consent form

I …….. agree to participate in the study conducted by Nardus Saayman.

I understand that:

- My identity will remain confidential at all times (unless otherwise requested), and that no identifiable features will be included in the final report or transcription
- The identity of my patients will remain confidential at all times, and that no identifiable features will be included in the final report or transcription
- There are no direct benefits to me in participating in this study
- There are no expected risks involved in this research
- My participation in this study is completely voluntary
- I reserve the right to refrain from answering questions, or to withdraw from the study prior to publication of the material without any negative repercussions

- Direct quotes may be used in the final report, but that no statement will be linked to me in a manner that would make me personally identifiable

Date ……..

Signature ……..

Recording consent from

I …….. agree to the digital recording of the interview conducted by Nardus Saayman. I understand that the recording will be transcribed verbatim.

I understand that:

- My identity will remain confidential at all times, and that no identifiable features will be included in the transcription of the recording
- The identities of my patients will remain confidential at all times, and that no identifiable features will be included in the transcription
- The actual recording will only be available to the researcher and his supervisor
- The recording of my interview will be stored in a password-protected file which will be destroyed two years after the completion of the study

Date ……..

Signature ……..

Appendix 2
Interview schedule

The interviews were be conducted in a semi-structured fashion. Thus the interview schedule viewed as a tool that guides rather than directs the question and answer process. Tell me about your work with psychotic patients.

- How have you come to be involved in this type of work?
- Have you received additional training in this type of work?
- Do you find that you work differently with psychotic patients compared to working with other patients? If so, in what way and why?
- What do you experience when working with psychotic patients?
- What do you find challenging about this type of work?
- What do you find rewarding about this type of work?
- How do you make sense of the role of the therapeutic relationship when working with psychosis?
- How do you make sense of the role of countertransference in this type of work? Do you ever find yourself working in or with the countertransference?
- How have your patients responded to your way of working?
- Have you sometimes found that working with psychotic patients confronts you with strange or psychotic feelings or experiences in yourself? If so, how do you make sense of this?
- If you have at times experienced psychotic feelings inside yourself, does it influence the therapeutic process, or how the patient perceives or experiences you? If so, in what way?
- Do you make use of supervision to support your work with psychotic patients, and if so, in which ways have you found it to be helpful and/or unhelpful?
- Is there anything that you would like to add?

Appendix 3
Ethics clearance certificates

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Saayman

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H15/02/41**
PROJECT TITLE	Psychodynamic psychotherapists' experiences of working with psychotic patients
INVESTIGATOR(S)	Mr B Saayman
SCHOOL/DEPARTMENT	Human & Community Development/Psychology
DATE CONSIDERED	20 February 2015
DECISION OF THE COMMITTEE	Approved unconditionally
EXPIRY DATE	8 March 2017

DATE 9 March 2015 **CHAIRPERSON** (Professor T Milani)

cc: Supervisor : Professor C Long

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ **Signature**

_____/_____/_____ **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Amended ethics clearance certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Dr B. Saayman

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M200464

NAME: (Principal Investigator)	Mr B. Saayman
DEPARTMENT:	Psychology
PROJECT TITLE:	Psychoanalytic Psychotherapists' Experiences of Working with Psychosis
DATE CONSIDERED:	20/05/2020
DECISION:	Approved
CONDITIONS:	Case study of 5 patients
SUPERVISOR:	Prof. C. Long
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	03/06/2020

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions.Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **May** and will therefore be due in the month of **May** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES