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THE FEARED THERAPIST: ON BEING PART OF THE PSYCHOTIC PATIENT'S PARANOID DELUSION

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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.

KEYWORDS: COUNTERTRANSFERENCE, DELUSION, PSYCHOSIS, PSYCHOTHERAPIST, 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 phenomenon when doing so.

As a result of a fragmentation of their subjectivity, psychotic patients 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, 1966). 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, 1957; 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-30s. 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 post-graduate study programme 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 healthcare 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 30 minutes into the 50-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 receive 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, let's 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).

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