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Volume 16, Module 2, Article 4, pp.215-236, 10-12-20 [copyright by author]

Response to Commentaries on: Portrait of a Man Imprisoned in an Altered State of Consciousness: The Case of "Sean"

Phenomenological, Epistemological, and Integrative Perspectives on the Case of "Sean"

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ABSTRACT

This article presents my response to commentaries on my case of "Sean" (Garrett, 2020) by Louis Sass and Jamie Walkup (2020), and by Paul Wachtel (2020). In my response to the Sass and Walkup commentary, I underscore what I consider their very astute observation that Sean seems to be aware that he himself can place Megan in a mental space where he relates to her, in which case she is an *object* of his subjectivity closely allied with his imagination, while he does not have the same experience of placing the CoF in an imagined scene because they are expressions of his own *subjectivity* rather than being objects of his subjectivity. Elsewhere in their commentary Sass and Walkup argue that delusions are not simply mistaken "truth statements" about the world (a view I share), which they believe might not be expected to respond to CBT techniques that examine beliefs. However, I think their emphasis of this point may have led them to a less than fully accurate account of my approach to and use of CBT, which I attempt to correct in my response. I also show why I believe some the Sean's awareness of his situation was a hard-won result of his treatment rather than a precursor to his psychotherapy. And I respond to their speculation that Sean might more properly be diagnosed as having a delusional disorder, a sentiment I do not share. I also question the validity of the diagnosis of schizophrenia and say why I prefer the more open-ended descriptor "psychosis."

Wachtel's commentary reflects the observations of an experienced clinician thinking about psychotherapy process. He understands what I am trying to do, and at times articulates the clinical process with Sean with greater clarity and in a wider context than would occur to me in my own words. His observations allow me to expand upon several points here. Specifically, (a) I acknowledge the lack of more information about Sean's family as an important limitation in the therapy; (b) I expand my description of the way in which I try to listen to patients and conduct psychotherapy; (c) I underscore Wachtel's observation that the primary conflict that appears in psychotic symptoms may be Oedipal (although this is not always so); (d) I agree with and elaborate Wachtel's idea that the past is not discovered in psychotherapy like a "woolly mammoth" unearthed in frozen tundra, but rather the past speaks through a living host that shapes its voice; and (e) I describe in more detail how the therapy process allowed me to over time to find a common language in the phrases "guilt loop" and "guilt work" in a way that advanced the therapy.

Key words: psychotherapy for schizophrenia; psychosis; delusion; therapeutic alliance; case study; clinical case study

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Drs. Sass, Walkup, and Wachtel provide enriching commentaries that raise important questions about what I have summarized about Sean's treatment and point out elements missing in my account. As the author of a target article, I found that the opportunity to receive commentaries on the article and then to have a good deal of time to respond to the commentaries was very worthwhile. On the other hand, a face-to-face discussion would have invited clarifying questions and emendations in the immediacy of the back-and-forth of the conversation. Repeatedly as I was reading the commentaries, I wished that Sass, Walkup, Wachtel and I were in the same room, if only a video chat room, where we could speak directly to each other and clarify our ideas in real time. Instead of the quick corrections of misunderstandings that occur in face-to-face conversations, it feels a bit as if we are talking by phone with a 3-month transmission delay. Accordingly, I feel somewhat uneasy having the last word in our exchange, knowing that they will inevitably feel that in some ways I have not gotten their ideas quite right. Keeping in mind these limitations, I will respond first to the Sass/Walkup commentary and then to Wachtel's observations.

RESPONSE TO SASS AND WALKUP

A Phenomenological Analysis of the Role of the Committee of Four (COF) and of Megan in Sean's Consciousness

First, I thank Sass and Walkup for their kind introductory remarks. Their praise is a much-valued part of their critique, but as they say, positive endorsements do not make for scintillating reading. So let me start by calling attention to an important and original observation in their commentary, and then engage with areas where I think we differ.

The understanding by Sass and Walkup of why Sean places Megan in a mental space but does not have the same view of Sean's Committee of Four (CoF) is brilliant. It probes deeply into Sean's mental life and has valuable implications for psychotherapy and psychoanalytic object-relations theory. I quote them here to remind readers of their idea:

> It seems that Megan largely functions in Sean's delusional universe as an *object* of awareness, of desire in fact, whereas the CoF guys are experienced by Sean more in the role of being *subjects* of awareness, indeed as subjects whose *own* object is usually Sean himself (whom they are engaged in monitoring and criticizing—something that Sean himself also does). The CoF men do not, then, in any sense appear directly, even in Sean's "mind's eye," so to speak. They are experienced *as* consciousnesses, and as such, may not have even a minimal sort of objectification that might make it possible for their reality to be doubted (Sass & Walkup, 2020, pp. 200-201).

This astute observation goes usefully beyond Bion's (1957) concept of *bizarre objects*, meaning mental representations of entities outside the boundary of the self into which certain mental operations of the psychotic person's mind have been projected. (For example, in psychosis, computer chips planted in the brain that monitor and transmit the patient's thoughts are bizarre objects that encapsulate the mind's projected self-monitoring capacities; i.e., the bizarre object is imbued with the capacity to carry out certain mental functions.) In the formulation of Sass and Walkup, bizarre objects such as computer chips are islands of *consciousnesses* (*subjects*) rather than *objects* of consciousness. It suggests that the more a

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delusional mental form operates like a *subject* (a consciousness) rather than like an *object*, the more difficult it may be for the person to achieve meta-psychological insight into the operation of his or her own mind. This is an important contribution, illuminating how phenomenological language and perspective can advance clinical thinking in ways that more traditional mainstream thinking might miss.

Their hypothesis about why Megan and not the CoF appear in Sean's mental space prompts intriguing questions for object-relations theory about how people divide (dissociate) consciousness and how they may partition their status as *subjec*t and *object of the subject's attention* by creating mental representations that more closely identify with one rather than another aspect of their conscious experience. Reframed in more traditional psychoanalytic language, in moments when we encounter our superego (in Sean's case, the CoF), we are both the *subject*-observer and the *object* of observation. In ordinary mental life, we typically identify with the object of the superego's scrutiny (i.e., the part of the self that feels the superego's lash), even though the superego is also part of the self. If we did not identify with the person receiving the lash, the superego would have no power. We would just be observing a stranger getting a beating. In the familiar defense of *identifying with the aggressor* the beleaguered self reverses its helplessness by identifying with the perpetrator who metes out punishment rather than the victim who receives it.

In the spirit of the Sass-Walkup formulation, the self being judged is the object of the superego's "mind's eye." There are not one but two channels of self-conscious self-awareness operating at such times—the superego observing the self that has fallen short of the ego ideal, and an observing self (the "observing ego") that can stand apart and observe the operations of both the superego and the self that winces with each stroke of the whip. A major goal in many psychotherapies, particularly for depressed patients, is to strengthen patients' abilities to take their own superego as an object of reflection, and in so doing to diminish its status as a free-standing authority and locus of consciousness. In the case of Sean and Megan and the CoF, we might say there are three subjects with different objects. Sean's subjectivity beholds Megan. The subjectivity of the CoF beholds Sean. And Sean beholds the CoF as an object of consciousness rather than as a form of his own consciousness (i.e., the part of the self that feels the superego's lash), making it more difficult for him to achieve the insight immortalized by Walt Kelly (in the comic strip Pogo) as "We have met the enemy, and he is us."

As to the parts of the commentary with which I have disagreements, I differ in four separate but related areas:

1. I believe Sass and Walkup have not accurately characterized my application of the CBT techniques in my approach;

2. I think that some of what they have assumed as primary and pre-existing in Sean's psychology was in fact a result of his treatment, not a precursor to it;

3. I question their implication that a sharp line can be drawn between schizophrenia or psychotic experience, on one hand, and nonpsychotic experience, on the other; and

4. I disagree with some premises that I believe drive their diagnostic argument.

Delusions Retain Some Characteristics of Beliefs, and to Some Degree, Under Amenable Conditions in Psychotherapy, Can Be Subject to Examination with Tools of Logic

The Issues

First, I should say that I greatly appreciate the addition a phenomenological perspective has made to my work. A seminal paper by Sass and Pieknos (2013) argues persuasively that delusions are not beliefs (truth claims) in the everyday meaning of this word. A previous paper by Sass and Parnas (2003) opened my eyes to the value of a phenomenological perspective toward psychosis and has had considerable influence on my thinking. In their commentary, Sass and Walkup stress the necessity of paying attention not only to the content of a delusion but also to how the person relates to what appears to be a belief. I agree that a delusion is not a mistaken belief in the usual meaning of this phrase, but I would emphasize that delusions retain some characteristics of beliefs, and to some degree, under amenable conditions in psychotherapy, can be subject to examination with tools of logic.

After all, in double bookkeeping, one set of books keeps a logical ledger. Some Cognitive-Behavior Therapy (CBT) clinicians prefer to refer to delusions as *maladaptive beliefs*, a term that declines the role of arbiter of reality and instead serves as a practical reminder that the delusion, whatever its epistemological status, is a source of suffering, is getting in the way of where the patient wants to go in life, and is therefore worthy of discussion. The CBT literature has a great deal to say about patients' attitudes toward their delusions. Delusions have multiple dimensions, which vary independently (Garety & Hemsley, 1987; Kendler, Glazer, & Morgenstern, 1983), including conviction, preoccupation, interference, resistance, dismissibility, absurdity, self-evidentness, reassurance-seeking, worry, unhappiness, and pervasiveness. Whereas conviction remains relatively stable over time in the same patient, the other attributes show variability. In keeping with the recommendation by Sass and Walkup to examine the form as well as the content of a delusion, these 11 variables describe the patient's relationship to a delusion without specifying content. Thus, the CBT literature has a lot to say about patient attitudes toward their delusions.

Sass and Walkup suggest that Sean may experience his delusion as not entirely real, that he may be loath to admit that he has already had thoughts of this sort before the therapist invited the question. As to his awareness that Sean "puts" Megan in a mental space, the same space in which the CoF appear, they state:

> The fact that he is conscious of having put the beings there with his own thoughts (and that they only appeared at that moment) suggests that he must sense, at some level, that these beings are not like the typical objects and persons of the real world, which would not of course depend in such fashion on one's own subjective thoughts. In this way Sean does not, in fact, seem to treat or to experience the CoF delusion as if it were akin to a normal belief. Indeed, one might be tempted to ask whether he does not, in some sense, betray or otherwise indicate his own ontological doubt, and respond protectively to Dr. Garrett's challenges, when he insists, as he does from time to time, that it is all very real. All this might suggest

> that, in fact, his delusional realm is *not* in fact fully real for him; and that, perhaps, he "doth protest too much" when he claims that it is (p. 198).

I have previously described (Garrett, 2019) the pitfalls facing therapists who adopt a binary attitude to reality or, in the spirit of our discussion, a binary ontology. In psychosis (and, to a subtle degree, in ordinary mental life) there are not two, but three distinct realms of experience that patients differentiate. Except in florid states, psychotic persons know when they are in the presence of an actual person. They have sufficient awareness of reality that they do not attempt to walk through walls. They also have a distinct feeling for what it is to imagine something, as in imagining that one can fly to the moon. They know how it feels to perceive the objective world and to imagine, and they know that the subjective experience of the delusion does not feel like either of these forms of experience. It feels like something else, something psychoanalysts have called *psychic reality*.

Sass and Walkup do not describe a tripartite ontology in psychosis. Rather, they describe a binary ontology captured by the concept of double bookkeeping. I think they missed one set of books. But they come close to a tripartite ontology when they quote Dr. Walkup's patient saying, "Don't you see they [the delusional beliefs] are in my mind and they are real" (p. 199). I hear this patient trying to describe his tripartite ontology to a world that thinks about reality in a binary way. He has words for only two categories of experience—"in my mind" and "real." The patient's "don't you see" marks his frustration that he cannot find a way to make the therapist "see" what he experiences. The conventional concept of reality-testing indeed does not do justice to psychotic experience, something I have written about at length (Garrett, 2019). Although Sass and Walkup circle around it, they not explicitly mention psychic reality, which in my view is the experiential seat of delusions.

As to the classic question, What did Sean know and when did he know it?, it is of course possible that even before his psychotherapy Sean had some inkling that Megan and the CoF did not reside in the outside world. I cannot know this for sure—nor, or course, can Sass and Walkup. In fairness to them, it may not have been clear from my summary, because I did not date the sessions, that Sean did not give a description of the room in which the CoF appeared until over a year into treatment. But even if he had had an intuition prior to psychotherapy that Megan and the CoF were not of the objective world, there can be no doubt that it took over a year for Sean to permit any discussion of where he locates Megan and the CoF. His willingness to describe where he saw them was a hard-won achievement of the psychotherapy. The idea that Megan and the CoF are contingent to his thoughts is precisely the insight I had been working toward for many months. I had to bide my time, as all therapists must, and wait, gently urging the discussion forward, hoping to find a moment when he might be open to talking about Megan and the CoF in a new way.

Early in therapy, he declined to describe the "room" in which the CoF operated their machine because he felt they might find this intrusive and therefore disrespectful, which would only add another offense to which they would hold him to account. As trust grew in our relationship, with persistence and many expressos drawn and drunk, he allowed me brief glimpses into his inner world. I quote him in my case write-up:

> "Mr. B is there and there are women's breasts on each of his shoulders."
>
> I asked him cautiously, how could that be, breasts on his shoulders? He said, "Yeah, like floating there, above him." I responded, "Oh, I see. They are floating in the air. So this room you are talking about can't be a real room because we both know that breasts can't float in the air like that. Sean, this room has got to be a mental room, a place in your mind where you think about things. Like you, men often think about women's breasts." He responded in an irritated tone, "Enough! Enough with the breasts. Let's move on." I guessed that I had already crossed the Rubicon of risking offense to the CoF, requiring that he shut down our conversation (p; 162).

In a subsequent session several weeks later (not quoted in my case report) I again inquired about the space in which the CoF appeared and asked him to describe what Mr. B looked like. He said Mr. B was sitting at a table facing him and that he "had his hair parted on the side," but he could not muster much more in the way of details. I used this opportunity to emphasize the implications of the breasts-over-the-shoulder session by pointing out to him that if a man were sitting turned toward him, and he saw a part in his hair, surely he would have seen other facial features. As in my remark about his imagining breasts rather than seeing them, I said, offhandedly as usual, that it sounded to me like he was imagining a man but wasn't able to imagine him in sufficient detail to fill out the features of his face.

With respect to Sean's resistance to seeing the CoF as a mental product, Sass and Walkup say that Sean feared that

> Dr. Garrett, might somehow attempt to demote or diminish the "reality" or the importance of his world. It may be a way of saying, in effect, "I see what you're doing or might do, and I don't want you to take this away from me by imposing your way of defining reality" (p. 197).

I think Sass and Walkup *understate* the importance of this issue in the treatment. Yes, he fears that the therapist and the psychotherapy may shift his ontological balance. Bion (1957) spoke of the psychotic person's having a hatred of reality because for many psychotic persons reality looks like Munch's painting "The Scream." That is a major reason why Sean resists the implications of his own observations. Tragically, to accept the idea that Megan and the CoF are not real in the way the therapist and his family are real threatens him with losing all hope. It takes time and trust and tact to work with attitudes in a patient that threaten the patient's psychological annihilation. In my case report, I noted,

> When he doesn't get his book deal and Megan, rather than feeling an accumulation of despair, he simply resets the clock to the beginning of a new week, and his hope is renewed. He is like a gambler who has already wagered the entirety of his adult life on a single bet, who cannot cash in his chips and walk away from the table. He has long since ceased to believe in his own powers of recovery. Rather than imagine a future he might build for himself his only efficacy is to please the CoF and be given his reward. The Oedipal father holds all keys to the kingdom (pp. 163-164).

Neuroleptic medication offers no solution to an ocean of grief. I also say the following, on the heels of our conversation about possible realistic engagements:

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> For now, my intention is to wait with him to see if he tires of waiting for his life to begin. I am not certain that he will ever be able to bear the loss of the dream contained in the delusion, in which case his life will have been only what it could be while imprisoned by his altered state of consciousness. A biological clinician who aimed to ablate the CoF delusion without understanding its meaning might consider its persistence an indication of a "treatment resistant psychosis." Tragically, the CoF is both his sorrow and his reason to keep living (p. 164).

What I try to show in the transcript of my therapy with Sean (Garrett, 2020, starting on p. 164), is that before a therapist can encourage a patient to doubt a delusion, the therapist must have something more to offer the patient. "You *imagined* the book deal" will not do. The therapist must help the patient find a viable exit strategy out of the delusion. In the session of the transcript, I was suggesting to Sean that he may have waited long enough for the CoF to deliver, and that although he might have to forego Megan, he might work toward the prize of regaining his privacy by understanding, at first intellectually and then more viscerally, that a reality TV audience was not privy to his thoughts.

Sass and Walkup (2020) write:

> We would suggest that what seems characteristic of many (not all) patients described as having delusions may be less a matter of some incapacity for "reality testing" (as is assumed in much of mainstream psychiatry as well as in CBTp) than a matter of something more like attitude or orientation: namely, the presence of some fundamental failure or refusal to commit to the basic reality of practical life in an intersubjective world (p. 199).

This paragraph is beautifully written, full of truth, and points to the heart of the psychotic person's dilemma. Although I assume that Sass and Walkup would not put it this way, their description of a state of mind in which neither the delusion nor the actual world is experienced as having the full quality of reality comes close to my view that delusions are experienced neither as objective reality nor as imagination, but as a compelling *psychic reality* about which psychoanalysts have much to say.

I hear an argument in the background of my critics' commentary that goes something like this.

- CBTp is a mode of psychotherapy for psychosis that regards delusions as beliefs (as truth claims).
- Delusions differ in fundamental ways from truth claims (beliefs).
- Ergo, any form of psychotherapy that regards delusions as beliefs that can be changed with CBT techniques that appeal to logic is fundamentally misguided.
- Sean's case illustrates this point. Garrett used CBT techniques and the CoF delusion didn't change all that much.

- Dr Garrett's case shows not only that the relationship is more important than CBT techniques, but also that CBT techniques might never in the first place be expected to have any impact of delusions because they are not beliefs that can be falsified in the way other truth claims might.

Here is where I infer that Sass and Walkup fail to characterize my use of CBTp accurately and fail to represent accurately my theoretical position about it; they also seem not to have a feel for how I apply it clinically. At the risk of mischaracterizing their position in parallel, let me exaggerate to make a point: They seem to have formed the impression that when using CBT, although I seem to be a nice guy who can foster an alliance, I am engaged in a humane, sensitive, but fundamentally misguided effort (because delusions are not beliefs) to harness the power of reality-testing to wrestle the delusion to the ground. That may be what some manualized CBTp treatments appear to assume, but it is not at all what my work feels like to me.

For me, it is more of a dance, in which patient and therapist respond to each other, move around each other cognitively and emotionally, sometimes approaching, sometimes taking flight. CBTp techniques are steps in the dance, and important ones, but far from the whole enterprise. My making the points to Sean that breasts don't hang in the air, and that men seen front-on have faces, is not an attempt to win an argument with logic, but rather to lead the dance in a direction more in touch with reality, a reality within which, despite his wishes to the contrary, he must live. By making the argument that the premises of CBTp are fundamentally flawed, they throw a serviceable clinical baby out with the bathwater.

Psychodynamic therapists at times appeal to logic. We tend not to call this "doing CBT," and yet I call my referencing consensual reality (reminding him that real people have faces and real breasts don't hover in the air) "doing CBT" because methodically, over time, I hope to encourage doubts in patients about whether delusions are literally true, and I have learned a great deal about how to do this from experts in CBT. Whereas previously Sean might have shouted me down and reiterated his conviction that the CoF were "real," on the occasion I depicted, he did not argue. He paused. I waited. And then he said, "OK! Enough with the breasts! Let's move on." And we did. Although he did not verbally endorse it, he had taken my point that the room the CoF were in was a mental space. This was a new dance step. While I cannot prove it, I think this conversation, the product of a year of a difficult psychotherapy, set the stage for his later acknowledgement that he "put" Megan in his mental space. His being able to hear a gentle challenge to his insistence that the CoF are "real" is one step toward his increased understanding of his predicament as mental rather than literal.

Similarly, I see as significant Sean's being able to joke about the delusion of the other patient, "Patient Z" (Garrett, 2020, p. 167). Sam believes that as he walks around Brooklyn, when anyone looks at him they are sending him a special message. I view Sean's joking about "Not everyone in Brooklyn" (p. 169) as an accomplishment of psychotherapy rather than as evidence of a pre-existing articulated awareness that the CoF have a different ontological status from that of members of his family. Did Sean have some awareness prior to therapy that those with whom he eats dinner are intrinsically different from Megan and the CoF? I cannot be sure, but I do not think this is the fundamental question. To me, the more basic issue is whether he had, before his work with me, any interest in talking to another human being to compare and

contrast his experiences of Megan and the CoF with experiences of his family. I think the answer to this question is no.

Instead of brushing the question aside as he always had before, after a year of my using CBT techniques while hanging out with him in the neighborhood of the CoF, he finally allowed the question of the ontological status of Megan and the CoF to enter our interpersonal space. This is an accomplishment of psychotherapy.

Although his acknowledging that he "places" Megan in a mental space marks an advance in his treatment, and although his concession that "all of Brooklyn" is an absurd idea is a mark of improving judgement, the "all of Brooklyn" remark functions also as a psychological defense against the use of logic in psychotherapy. In effect, he is plea-bargaining. He says yes, the all-of-Brooklyn idea is absurd, but the machine reading my thoughts is not. Following the work of Marcus (2017), who drew attention to non-psychotic defenses enlisted to protect delusions from change, I worked with colleagues at Weill Cornell Medical Center to develop a list of non-psychotic defenses by which psychotic persons may resist the use of logic in psychotherapy (Garrett et al., 2020).

As Sass and Walkup point out, CBT relies heavily, although not exclusively, on logic. A main point of the Garrett, Ahmed, et al. (2019) article is to show the limitations of CBT technique in patients who mount active psychological resistances to using logic—notwithstanding the effectiveness of CBT techniques with many patients who are more open to that method. Sean's concession "not everyone in Brooklyn" is an example of *logic partitioning*, wherein he plea-bargains with the therapist by conceding that one element in a delusional array defies logic without applying the same logic to the core belief. Other defenses Sean employs against the use of logic include logic evasion, reactive reassertion, and external expectancy. In our 2019 article we describe a total of 10 defenses against the use of logic that may limit the efficacy of CBTp.

Sass and Walkup write,

> …despite Dr Garrett's best efforts (including his almost herculean, albeit always diplomatic, attempts to convince Sean of the irrationality of his delusions), the patient at the end has still not fully distanced himself from his delusions (p. 201).

While they see no significant change in Sean as a result of CBT technique, they grant that the interpersonal relationship is of therapeutic value. I am not sure how quickly they expect delusions to fade in psychotherapy—please remember, I chose to write about Sean because he is one of the most challenging patients I have ever worked with—but Sass and Walkup seem to suggest that 18 months of once-a-week sessions is enough time for patients to distance themselves from their delusions. Considering that it is not unusual for 4-sessions-a-week psychoanalysis to take five years even with nonpsychotic individuals, I think Sean and I deserve some forbearance. By my math Sean's treatment so far adds up to 7.5% of that amount of clinical time in a typical analysis. I find myself wanting to say, "Hey, guys, Sean and I are working as fast as we can! Can we get an extension on that 18 month deadline?"

Cases in Which CBTp Techniques Worked to Alter Delusions

Not that delusions always show Sean's degree of resistance to influence. In my book (Garrett, 2019) on my integrated cognitive- behavioral and psychodynamic model, I have described a number of patients, three in great detail, who showed significant progress in an integrated CBT plus psychodynamic treatment. It took "Ariel" (Garrett, 2019, Chapter 14) 9 months to begin to let go of her delusions that she had a horrible smell and that her upstairs neighbors were spying on her. It took 4 months for "Asha" (Chapter 15) to accept that she was not responsible for her mother's having been hanged by a gang and to realize that she did not have a computer chip in her body. Prior to psychotherapy, Asha had been admitted to the hospital 3 to 4 times a year, despite antipsychotic medication. After psychotherapy, and with ongoing contact once or twice a month, she has never been readmitted.

Finally, "Kasper" (Chapter 15), who murdered his sister and father, believed that a church member had planted a hypnotic suggestion that induced him to do so. It took 9 months for him to distance himself from his delusion, accept that he had been acutely psychotic at the time of the homicides, and begin the process of grieving, which led to a modicum of self-forgiveness.

Here are some interventions that proved useful in a very short period. After one session in which I used primarily CBT techniques, a woman who was terrified that her cat planned to kill her reported in our second meeting, "I still think my cat plans to murder me, but I no longer think she has the means to do it." The CBT work gave us a space to talk in which she was not in fear for her life. It took additional psychodynamic work for her to understand that the cat delusion reflected her terror that her partner had fallen out of love with her. She imagined that the cat wanted to kill her to have her partner all to herself.

A 19-year-old man believed that a man and a woman entered his body when he was sleeping and had sex inside him. Using CBT techniques to raise questions about how two normal-sized people could enter and exit his body without a trace, I waited only 4 sessions before he concluded that his imagining a couple having sex inside him was a form of sexual daydreaming. He acknowledged that although he had never seen the nighttime lovers, he imagined that the woman looked like his first love, who had left him for a classmate when he was 16 years old.

And it also took 4 sessions of CBTp for a woman whose voices had predicted Frank Sinatra's death to realize that the voices were not omniscient, that they did not know anything she did not already know herself (she herself had thought Sinatra looked ill in his last several public appearances). The pace of psychotherapy is variable and rarely predictable. I chose to write about Sean rather than more rapidly successful cases to invite readers to think about the challenges deeply psychotic persons present in psychotherapy.

The Larger Context of CBTp Work

CBT techniques are important to my approach but do not dominate it. Sass and Walkup argue convincingly that delusions are not beliefs in the way we ordinarily think about beliefs as truth claims. I agree completely. I agree also that the failure of CBT theoreticians and clinicians

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to make specific mention of this fact is a significant limitation of a CBT-only approach. As Sass and Walkup say in their introduction, a commentary without challenges makes for dull reading. Perhaps out of their wish to sharpen their arguments about the general limitations of CBT, they more closely identified me with that orientation than is actually the case. It felt to me as if they had xeroxed my book and case summary but left in the copy machine the pages on which I talk about integrating CBT with psychodynamic technique.

For example, I have used the word *disavowal* to describe the state of mind of patients who are able to distance themselves from their delusions. Disavowal is different from a change of belief, such as thinking one left the car keys in the kitchen and discovering them in one's pocket. Disavowal is not an "insight" that the delusion is literally false. Rather, it is a change in the relative force of the psychotic side of the double-bookkeeping equation. When delusions recede as a result of psychotherapy, there is a significant reduction in suffering, but the delusion often remains in the background and may gain traction again in response to life stressors. That the outcome of psychotherapy with psychotic persons is more often than not a shift in the double-bookkeeping equation gives additional support to Sass's and Walkup's argument that a delusion is not a typical truth claim.

I have consistently said that CBT is a superior method to raise doubts that may help the patient see that that the delusion is literally false. Sass and Walkup attribute progress to the therapeutic relationship, not to a specific technique. I agree that the relationship is crucial, but it is not enough to effect substantial change. A therapeutic relationship is not entirely separate and apart from psychotherapy technique. The relationship emerges from doing something together. In Sean's case, in addition to our ritually sharing an espresso, our doing something together began with my inviting him to examine his belief that a machine could read his mind. Even though he was not convinced by logical argument that such a machine did not exist, discussion about the machine established our collaborative connection and planted seeds for future work.

Many months into the treatment, when CBTp work had become a familiar way for us to talk, I pointed out to him in an off-handed tone that people seen head-on have facial features, and women's breasts do not float in the air. Prior CBTp work had prepared the way for our being able to talk about his mental space. Psychodynamic techniques are a superior method for examining the figurative truth of psychotic symptoms. Sean named this aspect of the treatment doing "guilt work." I assume that breasts appear in his mental space because he is starved for attention, is terribly lonely, and has no sexual outlet, and so he thinks about women and their breasts and, more particularly, about Megan Fox and her body. Because he cannot sustain a relationship with a real woman beyond an occasional "rub-and-tug" at the massage parlor, he adds sexual imagery to his mental space. The stereotypical automobile mechanic has a *Playboy* centerfold posted on his garage wall; Sean posts a fragmented collage of Megan Fox on the wall of his mind.

Does Sean Meet Criteria for a Diagnosis of Schizophrenia?

If I understand their position correctly, Sass and Walkup regard "schizophrenia" as a definable disorder with reliable and valid diagnostic criteria. They regard changes in self-experience including diminished ipseity, hyper-reflexive self-awareness, and an overall

transformation of the perceptual field as more indicative of schizophrenia than a deficit in reality testing evidenced by a delusional belief. Accordingly, in their view, a patient like Sean who has been given a diagnosis of schizophrenia who does not manifest these features may have been misdiagnosed. However, there is little consensus among clinicians and researchers about what "schizophrenia" means. Herron et al. (1992) compared 16 different putative criteria for diagnosing schizophrenia and found that in only a minority of comparisons did interrater reliability rise to a modest kappa of .40. William Carpenter, MD, who has for many years been the Editor-in-Chief of the high impact journal *Schizophrenia Bulletin* states in a recent review that schizophrenia is a heterogeneous clinical syndrome and not a disease entity (Carpenter, 2016).

A careful reading of my case summary will show that I report diagnoses given to Sean by others. I never gave Sean a diagnosis of schizophrenia, not because I don't think he meets DSM-5 diagnostic criteria for schizophrenia (which he does), but because of the lack of specificity and validity in the diagnosis of schizophrenia. I prefer the more open-ended descriptor "psychosis" because it better fits the facts of the continuum of symptoms clinicians see in patients. As do Sass and Walkup, I regard alterations of self-experience as significant disturbances that are often overlooked in clinical assessment. In fact, I think an alteration of self-experience is central to Sean's condition. Although Sean's CoF delusion is the manifestation of his psychosis most apparent to the observer, in my view this belief can be seen as Sean's *post hoc* explanation of a profound alteration of self-experience that is not primarily diminished ipseity (Sass & Parnas, 2003). Rather it is an amalgam of hyper-reflexive self-awareness in which he is tracking his own thoughts coupled with a loss of the subjective sense of the privacy of his mind, a privacy that non-psychotic persons take for granted.

Patients who typically receive a diagnosis of delusional disorder do not experience a loss of the subjective privacy of their minds. The prototypical delusional disorder patient is a functional adult who believes that his or her spouse is having an affair or is convinced that he or she has a particular medical disorder despite evidence to the contrary. Patients given a diagnosis of delusional disorder are generally much higher functioning than Sean. Sean believes that he can hide nothing from the CoF, whether thoughts or actions, and he behaves as though his belief that his thoughts are being read has real-world truth implications, as can be seen when he is taken aback by a thought he has in session that seems to criticize the CoF. On such occasions he immediately lapses into anxious silence (a behavioral consequence to his belief), thinking he has just committed a thought-crime for which he will pay dearly in his Monday morning reckoning. The experience of having one's mind read and one's thoughts disseminated to millions fits a classic Schneiderian diagnosis of schizophrenia: thought-broadcasting. Mind-reading and thought-broadcasting do not appear in DSM-5 diagnostic criteria for delusional disorder.

Sass and Walkup point out that Sean experienced only certain events (horns and birds) as hyper-salient. According to their criteria, this specificity argues against a diagnosis of schizophrenia. Although I agree that in Sean's case the stimuli that he finds hyper-salient are conditioned by his delusion, I draw a different inference. It is important to remember that Sean was on antipsychotic medication during our therapy. All psychiatrists have seen instances in which neuroleptics calm the global hyper-salience of ideas of reference in acute psychosis, but none would conclude, after its pharmaceutical abatement, that the patient was misdiagnosed as

having schizophrenia. In my experience, the global hyper-salient illumination of the external world that one finds in acute psychosis often narrows down in chronic psychosis to a selective attentiveness to elements in the environment that resonate with personal psychological meaning. In a recent paper on the Bayesian brain and hyper-salience in psychosis (Garrett et al., 2019) I explored with colleagues the meanings that psychotic persons attach to particular hyper-salient stimuli. In the same way that in non-psychotic mental life an event during the day may resonate with a person's psychology and become a day residue around which a dream forms, psychotic persons pay attention to stimuli that resonate with their unconscious fantasy life. There are six case examples of such psychodynamically-driven hyper-salient meaning-making in the above-mentioned paper.

There is much more to discuss, but that goes beyond the context of this response to Sass and Walkup. I want to end this section by saying that because the issues Sass and Walkup raise are critically important to me, I have responded in great detail. Despite our differences of opinion, I want to express my enduring gratitude to Louis Sass, whose writing on the phenomenology of schizophrenia and psychosis has been highly illuminating to me, and my appreciation for Jamie Walkup's thoughtful contribution to their critique. The phenomenological view is a central tenant of the bio-psycho-social model of psychosis to which I continue to adhere. I believe we have begun to have a conversation here that has been in the offing for many years. Thanks, with much gratitude and admiration.

RESPONSE TO WACHTEL

In the spirit of our discussion of Sean's experience, I said to myself as I was reading Wachtel's commentary, "He can read my mind!" Wachtel understands what I am trying to do, and at times articulates the clinical process with Sean with greater clarity and in a wider context than would occur to me in my own words. There is little I can say that doesn't translate to yes, you have got it right, and thank you. My response will, I hope, emphasize points he makes and add something to his commentary.

An Alternative to Manualized Treatment

Wachtel rightly notes that my way of working is not a manualized treatment cued to a diagnostic category. Rather, he speaks of *principles* underlying clinical work. My work with patients is directed moment to moment by basic psychoanalytic/psychodynamic principles that guide me as to what to listen for, and a backdrop of ideas, including psychoanalytic object-relations theory and CBTp techniques, which I keep near at hand. In my clinical process (I think consistent with Wachtel's), when I begin to work with a patient, my first order of business is not gathering information to make a diagnosis which will then tell me what manual to use in the treatment.

Rather, it is as though I have a collection of index cards spread out on a table behind me that include not only notes about diagnosis, but elements of theory and vignettes accumulated in clinical experience. I listen to the patient's story (including the delusional part) as I would any story I read, see in a film, or hear from a non-psychotic person. As I listen, I ask myself where in

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the story I find fundamental human concerns. Who are the characters in the story? How does the patient relate to these characters? Why is the patient telling the story in this particular way, and how does the patient's version of events help to express and regulate his or her emotional world? Contrary to the claims of some psychoanalysts, no therapist can listen to a patient in a state of mind totally devoid of preconceptions. Theory and past experience always enter in. In my way of working, I try to keep the index cards behind me, or at least in my peripheral vision, so that what the patient says *reminds* me of one of my accumulated cards, which then invites a chain of thoughts that may or may not prove useful in understanding the patient.

To subdue a people, invaders must control the language they use. Much has been said and written in recent decades about *evidence-based practice*, with the implication that if you do not have a randomized controlled trial (RCT) in your wallet, the bouncer is not going to let you in to the club. This is a short-sighted philosophy. We need to speak equally of *practice-based evidence and practice-oriented research* (Castonguay, Youn, Xiao, Muran, & Barber, 2015), which is in short supply when RCTs are held up as the gold standard.

This is not to say that RCTs are not important; they are essential. But they are not the be-all-and-end-all of what we can know. There are significant limitations to RCTs when applied to the study of psychotherapy (Carey & Stiles, 2015). RCTs assume an independent variable (the treatment) and a dependent variable (the outcome of the treatment) and ensure that all subjects in the study receive the same treatment and all outcomes are measured by the same metric. But an emotionally engaged, well-conducted psychotherapy is not like this. The therapist changes the patient and the patient changes the therapist in a dialectic of human interaction that escapes the confines of independent and dependent variables. Said another way, although you can keep active medication apart from placebo, when you put two human beings in the same room, you can't prevent them from affecting each other. We are naturally affiliative. We change the people near us and are changed by them.

In my view, while trying to do evidence-based practice, some CBT-oriented clinicians work themselves into a corner when they too rigidly apply what is essentially a time-limited manualized treatment protocol, devised for studying a group of research subjects selected to eliminate confounding co-morbidities, as though a research protocol were a template for psychotherapy in the real world (Castonguay et al., 2015). The same can be said of manualized psychodynamic treatments. In the real world, co-morbidities don't graciously disappear, therapy does not conveniently finish up in the 10-week span of the grant-supported protocol, and the unpredictable happens. On the other hand, to the credit of the evidence-based movement, structure can discourage treatments from wandering aimlessly, only to return at week's end to where patient and therapist started. Some patients take to structured treatments more readily than an open-ended approach. A balance between structure and spontaneity works best for me.

A Family System Perspective

Wachtel accurately observes that the case summary lacks a family systems perspective. The only member of Sean's family I have met is his mother, who often accompanies him to sessions. I asked Sean early in treatment, and several subsequent times, if he would be willing to have his family come in for a meeting. His answer has always been the same—a brusque, "We

don't need that." I eventually stopped raising the issue. I am aware of the importance of family systems work and its demonstrated efficacy in programs like the Open Dialogue program in Scandinavia (Seikkula, 2011) that achieves strikingly positive results with first-episode patients. I have done some work with outpatient groups, and of course have on occasion spoken with extended family when treating a family member, but I am not trained to do family systems work. Nevertheless, on the basis of my limited experience, I suspect it is often the case that if the clinician can assemble the patient's immediate family members in a room, their collective wisdom will provide clues about what ails the patient.

The high expressed emotion literature (high EE) shows that the family atmosphere has a significant effect on the identified patient's wellbeing. Inpatient readmission rates are higher for patients from families with high levels of expression of negative sentiments toward the patient and lower in families who are tolerant and supportive. Family atmosphere is an important epigenetic factor. Tienari et al. (2004) studied 300 adopted-away children of mothers diagnosed with schizophrenia. The incidence of schizophrenia in the adoptee cohort who were brought up in families rated by the researchers as supportive was slightly higher than in the general population, showing that genes have some effect even in a positive family environment, while the incidence of schizophrenia in subjects raised by families judged as disturbed showed an eight-fold increase (Wynne et al., 2006).

Harry Stack Sullivan believed that the social failure that marks psychotic illness is shaped by interactions with the small number of people that constitute the person's immediate family. He constructed his inpatient service at Sheppard Pratt Hospital to mirror a supportive family, hiring attendants capable of a relaxed relatedness to psychotic patients. His innovations were an early example of what came to be known as "milieu treatment," an approach that in my experience is unfortunately honored in name only in public psychiatry these days.

I recall a patient I treated when I was a resident-in-training, a 17-year-old boy, who, at the completion of his parents' contentious divorce, chose to leave his mother and live with his father, in part because his father promised him a motorcycle and other indulgences. When the motorcycle never materialized and his father showed little interest in him, he tried to return home to his mother, hat in hand. His mother, having felt betrayed when he chose his father, delayed saying yes to his request. During one visit to "try out" his returning home, she picked up a newspaper containing an article about a man who had been murdered. She said to her son, "Your father is a bastard. Nothing would please me more to see him dead someday in the headlines." The message was clear. His ticket to readmission to his mother's house was his father's murder. He had his first psychotic episode the weekend after this experience with his mother.

Psychosis Is Not Always Pre-Oedipal

Wachtel is right that I am not predisposed to think that psychosis is always a pre-oedipal tale, although sometimes it is. With the exception of childhood onsets of psychosis, the vast majority of chronically psychotic adults did not become manifestly ill until adolescence or young adulthood, before and during which time they were subject to the classic anxieties that all human beings experience, as described in psychoanalytic theory—annihilation anxiety, fear of loss of

the mother (or primary caregiver), fear of loss of parental love, fear of loss of a precious body part, and fear of loss of the love of the superego.

Any of these anxieties may find expression in delusional form. For example, fear of loss of the mother or the mother's love is sometimes inferable in a delusion not uncommon in adolescence that one's real parents were kidnapped, replaced by dangerous interlopers who claim to be one's real parents. In Kleinian terms (Klein, 1935), this delusion guards against the loss of the fantasied "good mother" by postulating that the real parents may return some day to redeem the patient. The woman (the "bride-to-be of Jesus") briefly noted in my case study (Garrett, 2020, p. 137) who had been raped by her father allayed her fears of having lost a precious body part (her hymen) by claiming to have lost nothing because her anatomy was different from that of all other women.

Regarding annihilation anxiety, I once failed to help a man on an inpatient ward who believed that his internal organs were coated with a cancer he had contracted from his mother when she touched his penis at his birth. The cancer, he believed, had been arrested in a stalemate with his will to live, where the disease could not continue to engulf him as long as he maintained complete stillness. He spoke little, did little, and refused medication because he believed drugs would disturb the delicate balance that was keeping him alive. His delusion reflects annihilation anxiety in his fear that the cancer was engulfing his organs, his organs representing his psychological self. His delusion also includes castration anxiety (his mother infects his penis) and Oedipal strains in his belief that his mother is interested in his penis.

In my opinion, one of the longest wild goose chases in psychoanalytic thinking about psychosis was equating the psychotic person's loss of ego boundaries (which Wachtel highlights as a problem knowing what is "within one's skin or one's mind and what lies without") with a failure to negotiate the separation/individuation period in normal development. Tausk (1933) and Federn (1952) were among the first psychoanalysts to write about the breakdown of the "ego boundary" in psychosis, the mental perimeter that differentiates the self from the outside world. Admittedly, problems in attachment play a role in the history of many children who become psychotic as adults (Gumley, Taylor, Schwannauer, & MacBeth, 2014), but the failure to distinguish inside from outside, as when patients think they are the doctor rather than the other way around, or when a person believes that her beloved deceased pet has taken up residence in her stomach, cannot be equated with a failure at Mahler's rapprochement sub-phase.

Every psychiatrist knows that on occasion medication can shore up a breakdown in ego boundaries in a week or two, restoring a more accurate sense of what is inside and what is outside. When such improvement happens, it does not indicate that the patient has passed through separation/individuation in a fortnight. People who use recreational psychedelics can enjoy an oceanic merger with the universe that is not a transient regression to a pre-separation fixation. Adults who are psychologically enmeshed with their mothers are not inevitably psychotic. Equating a failure to distinguish inside from outside with a failure to separate psychologically from one's parent imposed a psychoanalytic idea on a complicated mental disturbance that has deep roots in both biology and psychology. If one has only a hammer, all problems seem to require a nail.

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The Bicamerial Mind

As for Julian Jaynes and the *Bicameral Mind* (1977), I read his book a long time ago and I cannot say I am all in. I recently read a wonderful translation of Homer's Odyssey by Emily Wilson (2017) and also Jonathan Shay's (1995) moving book, *Achilles in Vietnam*. In these two accounts of Homer's epic poems, there is little reference to voice-hearing, as one would expect were voices a central feature of ancient Greek consciousness. There is, however, ample evidence of a different sort of near-psychotic experience in which the Iliad and Odyssey are steeped—the relationship between mortals and the gods. In the Odyssey, for example, Athena seems to have a front-row seat to Odysseus's life, frequently intervening to direct events one way or another. Athena frequently shape-shifts, appearing in the guise of a mortal. If there is a psychiatric syndrome reminiscent of Athena's activity, it might be the Fregoli Syndrome (Mojtabai, 1994), in which a psychotic person believes that different individuals in the environment are actually the same person.

As Wachtel notes, Sean's experience of the CoF emulates the way the ancient Greeks and pantheistic societies have understood their relationship to the world that surrounds them throughout history. It seems to me the ancient Greeks experienced their gods as an omnipresent presence operating just behind the scenes of everyday life. This is the feeling psychotic persons have about delusional persecutors who observe them from a distance, intent on doing them harm. Zeus kept Odysseus at sea for a decade while he withheld the prize of loyal Penelope, his homeland, and his treasure; the CoF have withheld Megan Fox and a million-dollar book deal for almost a decade. In Sean's case, his autobiographical play staged in the real world has a familiar boy-wants-girl-but-doesn't-get-girl theme that we might see in a Broadway musical or other theatrical production.

Wachtel's "Woolly Mammoth" Account of Repressed Childhood Experience

I am in agreement with Wachtel's "woolly mammoth" account of repressed childhood experience. The past survives only through a living host. Not only does the present reshape the past as it channels affectively charged experiences, the remembered past is a dynamic portrait, not an analogue replica. Young children experience the past as a mixture of historical memories that can be consensually validated by others and fantasies that shaped the experience of the event at the time and its memory.

For example, a woman who was sexually abused as a child periodically sensed the presence of a male intruder in her apartment. Although she had never seen him, she "had a feeling" that he was very tall and thin. She could not make out his face as she imagined him. She had revealed something to me two weeks previously that she had never told anyone. When she was 4 years old, a man her parents and neighbors had hired to drive children to school took her to a local park.

> He made me sit down on his lap and then he touched me. I knew what he was doing was wrong, but I didn't tell my mother because I knew my mother would tell me not to say anything to anyone. In our culture no one talks about these things.

I asked her what she thought even an ordinary-sized adult man might look like to a frightened 4-year-old girl looking up at him. She understood immediately. "He would look very tall! And maybe I couldn't see his face. Maybe I don't want to remember his face." Like a day residue that sparks a dream, her fear of COVID's entering the safety of her apartment had reactivated memories and a felt presence of her childhood abuse—another time when her safety was violated.

As Wachtel observes, Sean's delusion is self-perpetuating. It is grafted to the present, whatever its Oedipal origins. The "guilt loop" has a fast cycle that can occur in minutes and a slower cycle that takes a week. In the fast loop, he notices that he has had a thought that he thinks the CoF will not like. The machine reads his mind and conveys this ill-advised thought to the CoF. He listens expectantly for a message from them and very soon hears one in the form of car horns or bird chirps or, as was once the case in my office, the sound of an ambulance. This illustrates how perceptual experience can be primed by expectations. The neuroscientist Anil Seth has made a dramatic demonstration of this effect by priming the audience to hear a sentence in a nonsense sound; they indeed hear it (see: https://www.youtube.com/watch?v=lyu7v7nWzfo&list=PLVgETsr_imvxOTP2VKpyMLvnJ7VHDbC69&index=64).

Sean's Week-Long "Guilt Loop"

Sean's week-long guilt loop, grounded in the cadence of the calendar, sustained Sean's capacity for hope. On Monday, when he heard the horns and knew this was not the week the CoF would be letting him off, he resigned himself to another week of trying to be good to win their approval. It seemed to me that a week was an apt time period for the cycle of judgment. If he had to wait any longer, it might feel too long to keep his hopes up. Most of us can wait a week for a prize. Being made to wait only a day until his next reckoning would be too short a cycle, a turbulent daily whipsaw of hopes rising and being dashed that would be emotionally unsustainable. So Sean lived week by week for years, with every Monday his day in court. The weekly cycle sustained the delusion in the present because the CoF not only tormented him; they were also his ticket to a wonderful future with Megan and money, the only future he could imagine. Suicide in psychosis is, understandably, not uncommon. Sean was not suicidal. He had devised a mental mechanism to stay alive in an impoverished landscape.

Wachtel writes,

> Here Garrett subtly and implicitly attributes to Sean an attitude he would deny if stated explicitly (e.g., "you feel their standards are impossibly high"). At the same time, by calling attention to what it is that Sean *would not* say, he exposes Sean *to* that idea …. And even associatively links it to Sean, while still providing Sean the deniability that enables him to keep listening. We have, then, a form of what I have called "attributional" interpretations (Wachtel, 2011) as well as a form of graduated exposure therapy, in which Sean is exposed to some of the cues associated with having that (forbidden) thought, but not more than he can handle at that point (p. 209).

Wachtel is right on target. As is probably the case for most therapists, some of what I do with patients is guided by conscious intent and some is directed by intuition that is not

consciously articulated. When I read this part of Wachtel's commentary, I said to myself something like, "Yes, of course. That is what I am doing. I never conceptualized it in quite that way."

Another example in which I—but not Sean—was able to say that the CoF were unfair came from time to time in sessions when I would start by asking him, "So how was your week?" Sean would reply, "I had a good week. I *thought* I had a good week, but they still didn't let me off." At such times I underscored the unfairness of his being judged for crimes unknown, making clear, as if the CoF were listening, that the objections raised were mine and not Sean's. I might then say, "So even when you have a good week and you keep up your side of the deal the CoF don't keep their side of the bargain. That's not right." Unlike early in treatment, when he might have silenced me for fear of giving the CoF offense, he allowed me to say such things a year into treatment. But after listening, and pausing, he might say, "I think it's going to happen this week"—meaning that next week would bring his reward. My being the fall guy with the CoF allowed him to weep once in a session when he was feeling deeply aggrieved by his plight.

Again, Wachtel captures the slow, accumulative process of the work where advances sometimes occur before either the patient or the therapist is consciously aware of the change.

> In Garrett's efforts to find the crack and create leverage, he relies substantially on methods that derive from CBT, methods he applies with admirable flexibility, creativity, and simple patience and persistence, a willingness to go over the same material week after week in the hope of slowly getting to a tipping point (Galdwell, 2000) where change that has silently been building can suddenly be manifested in a noteworthy transformation (p. 210).

And as Wachtel recognizes, I am trying to slowly dial down his exclusive investment in the CoF as guarantors of a future that will never come. Over time I try to blend in other possible rewards, such as the return of his sense of privacy—knowing that at first, he might cognitively endorse but not viscerally feel a change in this subjectivity. Along with the recovery of his privacy, I mention a life freer of guilt and more open to real-world possibilities, such as joining a patient-oriented clubhouse or community center, where he might find friends, and even a girlfriend, and work, however modest compared to the Hollywood standard.

The Role of the Therapeutic Relationship

Wachtel is right that I am not trying to wrestle the delusion to the ground with logic, a strategy that rarely if ever carries the day. In Joanne Greenberg's (1964) account of her psychotherapy with Frieda Fromm-Reichmann, she describes her experience with a psychiatrist who once filled in during Fromm-Reichmann's absence. The stand-in doctor used logic to show Greenberg that the words spoken in her private delusional world of Yr were actually not a secret language at all but were derivatives of Greenberg's English usage.

He had taken the first words she gave him and shown her the roots of them from scraps of Latin, French, and German that a nine- or ten-year-old could pick up if she tried. He analyzed the structure of the sentences and demanded that she see that they were, with very few exceptions, patterned on the English structure by which she, herself, was bound. His work was clever and detailed and sometimes almost brilliant, and she had many times to agree with him, but the more

profound he was the more profound was the silence which enveloped her. She could never get beyond the austerity of his manner or the icy logic of what he had proven, to tell him that his scalpels were intrusions into her mind just as long-ago doctors had intruded into her body, and that furthermore, his proofs were utterly and singularly irrelevant.

The covering doctor used cold logic but offered no emotional warmth. Without relatedness, Greenberg experienced his admittedly brilliant comments in the transference as intrusive violations, the traumatic intrusiveness she had felt when she had a urological surgical operation as a child. It is the therapist's real relatedness with the patient that leads him or her to trust the therapist enough to pay attention to what the therapist has to say. Although effective CBTp therapists pay attention to the therapeutic alliance, they do not conceptualize and use an understanding of the transference in the way psychodynamic clinicians do. Although the following caricature of CBT does not do justice to sensitive CBT practice, I offer it to make a point. According to the CBT model first articulated by Beck et al. (Beck, Rush, Shaw, & Emery, 1987), in which beliefs mediate between life events and affective responses, the CBT therapist might argue that Greenberg had a dysfunctional belief that her substitute therapist was subjecting her to an unwanted a surgical operation. Although this would in one sense be true, without the relational richness of the transference, a predominately cognitive formulation of the problem misses the heart of the matter.

Another way of saying what Wachtel has already said so well would be to conceptualize the feeling of CBT as I use it with psychotic patients as the interlacing of two languages rather than a logical argument in one language. Let us say Sean's native language was English, but he had also heard Spanish spoken in his neighborhood. This metaphor may be too far a stretch, but I will give it a try anyway. In Sean's inner world, where he is implicitly in a dialogue with the CoF, a peculiar form of English is spoken in which there are no words to formulate questions about the ontological status of his life experience. He encounters a therapist who, every once in a while, uses a "Spanish" word or phrase in the conversation—read here a statement that brings logic to bear on his delusion.

First, he tolerates me using Spanish because he is lonely and wants to feel connected to another person. Then he gets used to my using Spanish, teasing me at times as if to say, "There you go again speaking Spanish. I don't speak Spanish." My asking questions about Sean's experience helped him to develop a subliminal Spanish vocabulary, which eventually allowed him to reach for a Spanish phrase in his own thinking about himself, as when he describes how Megan and the CoF appear not in an actual room but in a mental space. The feel of CBT work as I practice it with a psychotic person is not an effort to win a logical argument by amassing evidence against the delusion, but rather more like an interlacing of two languages with the aim that Sean will be able to think about himself in new ways. Logic does not win the day once and for all, nor can I predict exactly when Sean might reach for Spanish, but I am trying to give him a new vocabulary with which to think about his life.

Said another way, I am trying to shift the balance between emotional, symbolic primary-process thinking (which dominates Sean's mental life) and logic-based, secondary-process thinking. In *Interpretation of Dreams*, Freud (1900) characterized secondary-process thinking as the ego's prime modality of adaptation to reality. I view my role as psychotherapist as giving

Sean more of a choice than he has now. Either he will wait forever for the CoF to unite him with Megan and a lavish lifestyle, or he will find the strength to grieve this aim, with the help of therapy, and live as a more common man less burdened by guilt who may entertain the idea that, despite subjective illusions to the contrary, perhaps the privacy of his own mind remains intact, as has been the case all along.

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I very much enjoyed this exchange with the commentators. I learned new things while responding to their observations, felt affirmed in some of the convictions I hold, and had a good time in the conversation all the while.

REFERENCES

Beck, A., Rush, A. J., Shaw, B., & Emery, G. (1987). *Cognitive Therapy of depression*. New York: Guilford.

Carey, T. A., & Stiles, W. B. (2015). Some problems with randomized controlled trials and some viable alternatives. *Clinical Psychology & Psychotherapy, 23*(1), 87-95.

Carpenter, W. (2016). John S. Strauss and schizophrenia: Early discovery, lasting impact. *American Journal of Psychiatric Rehabilitation, 19*(1), 3-11.

Castonguay, L. G., Youn, S. J., Xiao, H., Muran, J. C., & Barber, J. P. (2015). Building clinicians-researchers partnerships: Lessons from diverse natural settings and practice-oriented initiatives. *Psychotherapy Research, 25*(1), 166-184. doi:10.1080/10503307.2014.973923

Garety, P. A., & Hemsley, D. R. (1987). Characteristics of delusional experience. *Eur Arch Psychiatry Neurol Sci, 236*(5), 294-298. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/3653151

Garrett, M. (2020). Portrait of a man imprisoned in an altered state of consciousness: The case of "Sean." *Pragmatic Case Studies in Psychotherapy 16(2),* Article 1, 132-194. Available: http://pcsp.libraries.rutgers.edu/

Garrett, M., Ahmed, A. O., Athineos, C., Cruz, L., Harris, K., Del Pozzo, J., . . . Gallego, J. (2019). Identifying psychological resistances to using logic in cognitive-behavioral therapy for psychosis (CBTp) that limit successful outcomes for patients. *Psychosis, 11*(4), 287-297. doi:10.1080/17522439.2019.1632377

Garrett, M., Brereton, A., Forster, V., Ifrah, C., Katz-Tucker, M., Martin, V., & Sims-Ford, V. (2020). The Bayesian brain and psychoanalytic dimensions of hyper-salience in psychosis. *Current Behavioral Neuroscience Reports, 7,* 158-164.

Gumley, A. I., Taylor, H. E., Schwannauer, M., & MacBeth, A. (2014). A systematic review of attachment and psychosis: Measurement, construct validity and outcomes. *Acta Psychiatr Scand, 129*(4), 257-274. doi:10.1111/acps.12172

Herron, W. (1992). A comparison of 16 systems to diagnose schizophrenia. *Journal of Clinical Psychology, 48*, 711-721.

Kendler, K. S., Glazer, W. M., & Morgenstern, H. (1983). Dimensions of delusional experience. American Journal of Psychiatry, *140*(4), 466-469. doi:10.1176/ajp.140.4.466

Klein, M. (1935). A Contribution to the psychogenesis of manic-depressive states. *International Journal of Psychoanalysis 16,* 145-174.

Mojtabai, R. (1994). Fregoli syndrome. *Australian New Zealand Journal of Psychiatry,* 23(3), 458-462.

Sass, L. A., & Parnas, J. (2003). Schizophrenia, consciousness, and the self. *Schizophrenia Bulletin, 29*(3), 427-444. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/14609238

Sass, L.A., & Walkup, J. (2020). Virtual realities: On delusion, shame, and intersubjectivity. *Pragmatic Case Studies in Psychotherapy 16(2),* Article 2, 195-205. Available: http://pcsp.libraries.rutgers.edu/

Seikkula, J., Alakare, B. & Aaltonen, J. (2011) The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis, 3*:3, 192-204, DOI: 10.1080/17522439.2011.595819

Wachtel, P. L. (2011). Therapeutic communication: Knowing what to say when, Second Edition. New York: Guilford

Wachtel, P.L. (2020). The keys to the prison: Michael Garrett's integrative approach to the treatment of psychosis. *Pragmatic Case Studies in Psychotherapy 16(2),* Article 1, 206-214. Available: http://pcsp.libraries.rutgers.edu/

Wynne, L. C., Tienari, P., Sorri, A., Lahti, I., Moring, J., & Wahlberg, K. E. (2006). II. Genotype-environment interaction in the schizophrenia spectrum: qualitative observations. *Fam Process, 45*(4), 435-447. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17220113