

## Portrait of a Man Imprisoned in an Altered State of Consciousness: The Case Of "Sean"

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### ABSTRACT

This case study describes the first 18 months of weekly psychotherapy with a man suffering from a debilitating chronic psychosis that centers around his conviction that a group of four older men that he refers to as the Council of Four (CoF) operate a machine that can monitor his thoughts to determine if he is having disrespectful thoughts toward them. The patient lives in an altered state of consciousness in which the privacy of mind that people generally take for granted has dissolved. Every Monday the CoF sends him a Morse-code-like message conveyed by automobile horns. It is his belief that if he can meet the standards of the CoF they will reward him with a lucrative book deal and movie contract, which will allow him to approach a female movie star of whom he is much enamored. This case study describes a treatment approach that integrates cognitive-behavioral therapy (CBT) and psychodynamic technique, where CBT techniques are used to consider the literal falsity of the CoF idea while a psychodynamic approach is used to examine the figurative truth of the delusion by exploring the meaning of his subjugation to the CoF.

*Key words:* psychosis; delusion; mind reading; ideas of reference; psychotherapy for psychosis; therapeutic alliance; case study; clinical case study

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## 1. CASE CONTEXT AND METHOD

In this case study I describe the psychotherapy of a man in his late 30s that occurred in once-a-week 45 minute sessions over a period of 18 months, a man who believes that a group of older men he calls the Counsel of Four (CoF), consisting of a Mr. A, Mr. B, Mr. C, and Mr. D, operate a machine that can read his mind. They employ the machine to monitor his thoughts for evidence of disrespectful sentiments he might direct toward them. He lives in an enduring altered state of consciousness in which the sense of privacy we ordinarily assume shields our mind from public view has largely dissolved, leaving his inner subjective world open to inspection by the CoF and a national audience. He spends his weeks imprisoned in a virtual reality in which he is serving a life sentence for thought crimes. Once a week, on Monday morning, the CoF sends him a Morse-code-like message via rhythmic sequences of automobile horns and/or the chirping of birds in his neighborhood which indicate whether his thoughts and actions merit their "letting him out," meaning they will cease their surveillance. At the time he began psychotherapy the surveillance had been in place for 8 years without respite. All clinical material in this paper is

disguised in keeping with generally accepted guidelines for clinical writing (Cliff, 1986).

I work in a publicly funded psychiatric clinic in inner-city Brooklyn, New York, where I provide psychotherapy to psychotic persons and teach and supervise other clinicians doing the same. After the introduction of the neuroleptic medication chlorpromazine in the 1950s, psychopharmacology became the treatment of medical choice for schizophrenia, psychotherapy for psychosis became an endangered species, and psychosocial supports such as residential housing and monthly disability checks continued in anemic fashion much as before. Compared with recent advances in cardiology, oncology, and other branches of medicine, long-term outcomes in the biological treatment of schizophrenia are quite disappointing, with most chronically psychotic persons consigned to lives of protracted suffering and unending disability (Harrow, Jobe, Faull, & Yang, 2017; Walkup & Gallagher, 1999). Neuroleptics help some patients live in the community by diminishing acute symptoms and reducing relapse, but when patients describe how they feel on such medications, they often report an anesthetic-like effect in which delusional ideas persist but are experienced with less agitated concern (Mizrahi et al., 2006)

Despite the dominance of biology in the last 60 years, psychotherapy with psychotic persons has a long tradition dating back to the 18th century. Every generation of clinicians in the last millennium includes individuals devoted to the psychotherapeutic treatment of psychotic persons. Although Sigmund Freud did not treat psychotic patients in classical psychoanalysis, many of his clinical observations stand in good stead today. Psychoanalytically inclined clinicians may be most familiar with his writing about psychosis in the *The Case of Schreiber* (Freud, 1911), which rightly emphasized the importance of projective defenses, but wrongly held that homosexual conflicts are the core dynamic in paranoia. But many may be unfamiliar with a less well-known paper about Frau K, a clinical gem of a case history in which Freud explores the psychology of common psychotic symptoms such as ideas of reference (Freud, 1896). A list of clinicians in past decades who have particularly influenced the therapeutic model I have developed (Garrett, 2019) and to whom I am personally indebted would include Paul Federn (Federn, 1952), Karl Abraham (Abraham, 1923), Melanie Klein (Klein, 1935, 1946), Herbert Rosenfeld (Rosenfeld, 1965), Silvano Arieti (a giant among clinicians; Arieti, 1974), Bertram Karon and Gary Vandenbos (Karon & Vandenbos, 1981), and more recently Ira Steinman (Steinman, 2009), David Garfield (Garfield, 2009), George Atwood (Atwood, 2012), Andrew Lotterman (Lotterman, 2015), and Eric Marcus (Marcus, 2017).

Almost without exception, patients suffering from chronic psychosis are treated in the public sector, if for no other reason than few individuals or families can bear the cost of years of treatment, which often includes repeated hospitalizations. Although medication is the de facto standard of treatment, the widely recognized Schizophrenia Patient Outcomes Research Team guidelines (PORT Guidelines), first published in 1992 and revised in 2009, recommends cognitive behavioral psychotherapy in addition to a variety of pharmacological approaches (Kreyenbuhl, Buchanan, Dickerson, Dixon, & Schizophrenia Patient Outcomes Research, 2010; Lehman et al., 2004).

Persons with schizophrenia who have persistent psychotic symptoms while receiving adequate pharmacotherapy should be offered adjunctive cognitive behaviorally oriented

psychotherapy to reduce the severity of symptoms. The therapy may be provided in either a group or an individual format and should be approximately 4-9 months in duration.

The British best-practices NICE Guidelines include a recommendation that individual CBTp be offered to 100% of persons with a diagnosis of schizophrenia in 2015 (National Institute for Health and Care Excellence Quality Standard 80, at <https://www.nice.org.uk/guidance/qs80>). However, despite the international consensus reflected in these guidelines, a significant gap remains between what has been recommended and the operational reality in public mental health. Lehman (2009) notes a "science-to-service" gap in the treatment of schizophrenia in which frontline clinical practices often do not mirror evidence-based recommendations (Lehman, 2009). Although all but the most impoverished hospitals claim in their mission statements that they provide psychotherapy to psychotic patients, few, if any, hospitals in the public sector provide more than supportive counseling. What passes for psychotherapy in community clinics is insufficiently ambitious to achieve a significant degree of recovery. As one clinician remarked about her patients, "I try to bear compassionate witness to their suffering, but I really can't do anything to change their condition."

There are many reasons public institutions talk the talk but don't walk the walk. Compared with 15-minute "medication checks" once a month by a psychiatrist who is "following" 200 or more patients, weekly 45-minute psychotherapy sessions cost time, salary, and the expense of training and supervision. Because clinic staff spend roughly half their time at work "documenting" rather than working directly with patients, a psychotherapist who worked exclusively seeing patients once a week for 45 minutes could carry a census of no more than 15 patients. Currently, caseloads are often 80 or higher. These numbers cut to the chase: little in the way of ambitious psychotherapy can be provided with caseloads this high, no matter what the clinical policy manual says.

Another reason that biology dominates psychotherapy in actually provided treatment is the pervasive pessimism inherent in the conviction that "schizophrenia" is fundamentally a chronic brain disease for which we have yet to find the biological cure. In accord with this assumption, frontline clinicians may feel that they are holding the fort until a biological messiah arrives. Waiting for a biological cure provides an endless rationale for therapeutic failure. If clinicians and administrators don't really expect patients to recover, they think less about what else could be done now and content themselves that all that is possible is already being provided. The idea that better outcomes might follow more ambitious psychotherapy doesn't enter the equation.

After working as a psychiatrist, psychotherapist, and administrator in public psychiatry for 30 years, in the last 15 years my hospital duties have allowed me to devote an increasing amount of time to treating psychotic patients in psychotherapy and supervising psychiatric residents and other clinical staff doing psychotherapy. I have myself treated over 50 chronically psychotic patients and consulted in the treatment of many hundreds more. This experience has allowed me to learn from the work of other clinicians and to be exposed to psychological work with a higher number of psychotic patients than most clinicians typically have in their practices.

## 2. THE PATIENT

The patient, whom I will call "Sean," is the youngest son in a large Irish-American family, born to parents who immigrated to the United States after World War II. His father is a certified public accountant and his mother works as an administrative assistant for a local politician. He was 37 years old when he began psychotherapy. The onset of his chronic psychotic illness came in his early 20s. Subsequent to that, he was unable to work for any extended period, and then only in low-demand jobs, such as running errands for his older brother, who ran a successful landscaping business. Sean was unable to provide a coherent timeline of his psychiatric treatment, but his mother provided an overview. Between his early 20s and age 37, he was hospitalized on an inpatient psychiatric unit 10 times. Over time, he received multiple diagnoses, including bipolar disorder, schizophrenia, and schizo-affective disorder, and during the course of his illness he had been treated with multiple psychotropic drugs: neuroleptics, lithium and other mood stabilizers, and benzodiazepines, none of which had any salutary effect on his core delusion about what, as mentioned above, involved a group of older men called the Council of Four (CoF), consisting of a Mr. A, Mr. B, Mr. C, and Mr. D. At the time he was referred to me, he was being treated by an expert psychopharmacologist who had prescribed clozapine, gabapentin, lithium carbonate, and clonazepam. His prescribing psychiatrist felt that the medications helped Sean to remain calm and sufficiently well-organized to live in the community, but given his long history of taking medication with only modest improvement, she wondered if psychotherapy might encourage additional gains. She knew that psychotherapy can sometimes lead to improvement even in medication-resistant patients (Rathod, Kingdon, Weiden, & Turkington, 2008).

Sean believed that the CoF operate a machine that can read his mind to monitor his thoughts for evidence of disrespectful sentiments toward them. On Monday morning they send him a Morse-code-like message which he discerns in sequences of automobile horns and bird chirps. They indicate whether his thoughts and actions merit a decision to discontinue their surveillance. Three beeps indicate he has not passed muster, and the surveillance persists. One beep would indicate that they will "let me out." Sean believes that the CoF also control robot birds that have the appearance of ordinary creatures but are actually machines that participate in observing him and sending messages to him. He believes that the machine that monitors his thoughts broadcasts on a live, video-feed reality television show that is watched by millions of people, which he takes as an indication of his potential business partnership with the CoF. As he puts it, "There are millions of dollars on the table." He believes that when the CoF are satisfied that he has been sufficiently respectful, they will include him in a lucrative book and movie deal about his life that will make him rich. At that point he intends to move to Los Angeles where, decked out with his new fame, fortune, and wealth, he will begin dating the movie star Megan Fox. Sean was preoccupied with these concerns to the exclusion of almost all unrelated mental life or physical activity.

### 3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

#### *My Combined CBTp and Psychodynamic Model*

While others have written about the integration of CBT and psychoanalysis (Wachtel, 1989), I integrate cognitive behavioral therapy for psychosis (CBTp) with a psychodynamic approach that recognizes the importance of the phenomenology of psychotic experience, and the role biology plays in the genesis and treatment of schizophrenia (Garrett, 2019). Psychotic persons in general believe that the source of their suffering is located in the outside world, often taking the form of a persecutor such as the CIA, the Devil, or a derisive voice intent on tormenting them. They conceive of their dilemma as an interpersonal problem between them and their persecutor rather than an intrapsychic problem in their psychology. Abuse and neglect in childhood, which are not uncommon realities in the world, significantly increase the likelihood of psychosis in later life (Varese et al., 2012). For example, a person who has been raped and who experiences symptoms of PTSD carries an 18-fold increase in risk of psychosis (Scott, Chant, Andrews, Martin, & McGrath, 2007). The psychotic person's travail often begins in the real world, with traumatic life events such as sexual, physical, emotional, or psychological abuse, neglect, parental death, bullying, foster home placement, or other psychosis-predisposing adversities, that are internalized as traumatic memories and fear-driven internal object relations (Garrett, 2016). The psyche of the victim absorbs the real abusers of childhood and then projects them back into the outside world in the form of persecutors perceived to be located there. In Sean's case, the CoF are his persecutors, whom he believes are located in a room in front of the console of the mind-reading machine.

It is difficult to engage patients in an ambitious psychotherapy that explores their psychology when they believe that their problem does not originate within themselves but rather is located in the outside world. Patients who are so inclined want the therapist to help them battle their persecutors, not analyze their minds. When therapists suggest too early in treatment, however gently and tentatively, that there might be a psychological dimension to the patient's problems, the patient most often feels misunderstood and dismissed. For example, if a patient were to invite the therapist to call the police to protect him or her from a neighbor who was trying to poison the person, any turn toward psychology would be experienced as the therapist's saying, "I can't help you with the person who is trying to kill you, but I can talk about how you feel while you are trying to manage in this situation." The therapist must aim to move the persecutor closer to the patient's psychology before the psychosis can be examined in an ambitious psychotherapy. Integrating CBTp with a psychodynamic approach helps accomplish this goal.

CBTp relies on logic to examine maladaptive beliefs, with the aim of developing alternative explanations for the patient's anomalous psychotic experiences (Beck, Rector, Stolar, & Grant, 2009). Psychodynamic psychotherapy aims to interpret the meaning of thoughts, feelings, and behaviors. To the extent that psychotic symptoms follow in the aftermath of real-life adverse experiences, simultaneously they are literally false but figuratively (that is, metaphorically and symbolically) true. CBTp is a superior method for examining the literal

falsity of delusional beliefs. Psychodynamic psychotherapy is a superior method for exploring the figurative truth of psychotic symptoms. A combination of these two methods offers amenable patients a comprehensive, ambitious, thoroughgoing approach.

For example, I once worked with a woman who had been repeatedly raped by her father whom she believed she was the bride-to-be of Jesus. She had come to believe that her pelvic anatomy was different from all other women, consisting of an outer chamber that had been breached by her father and an inner chamber that remained intact in anticipation of her wedding night with Jesus. Her belief that her anatomy was unique was literally false, but it was a figuratively truthful expression of her desperate attempt to imagine that her life had not been ruined by her father and that she could now look ahead to a divine marriage.

In psychotherapy with a psychotic person I start with CBTp techniques to encourage a recognition of the likely literal falsity of delusional beliefs. If I am successful in helping the patient entertain doubts about the veracity of the delusion, in the spirit of CBTp I invite the patient to consider alternative beliefs in the form of a psychodynamic interpretation of the person's psychotic experience.

In CBTp parlance, a psychodynamic interpretation is an alternative explanation of experience. Unlike the structure of DNA, which is known by empirical observation under a microscope to be a double helix, a fact that brooks no reinvention, psychological concepts are expressed in words that allow people to say the same thing in different terminology. Unlike organic chemistry, psychology is a word-based medium. The art of psychotherapy has advanced since Freud's day, and many writers have made original and valuable contributions to the psychological literature. But, because understandings of psychology and psychotherapy depend primarily upon words, a certain amount of pouring old wine into new bottles occurs in our field. At worst, this reflects a failure to be sufficiently well-read or a reluctance to acknowledge one's sources. At best, it can be understood as a replication process (akin to replicating the results of a randomized controlled trial by finding similar data in a second study), whereby the scholars of one generation independently rediscover what has been seen and known by those of previous generations. Here is an example of such replication, one that knits psychodynamic theory together with cognitive-behavioral technique.

In his *Interpretation of Dreams* (1900), Freud described two different modes of thinking—*primary process* and *secondary process*—and later conceptualized the *ego*, composed of psychological processes that mediate conflicts between the primary-process, emotion-laden demands of the id and a logic-driven model of external reality that fosters social and physical survival. The cognitive-behavioral/dialectical tradition similarly speaks of three different states of mind: emotion mind (Freud's primary process), reasonable mind (secondary process), and wise mind (the ego; Linehan, 2015). I greatly value CBTp techniques and believe psychotherapy with psychotic persons often founders without it. Unlike CBT theory, however, which in its inception claimed that *beliefs* mediate between events and the emotions and behaviors they trigger, a view that sees affect as a downstream consequence of belief, psychoanalysis assigns affect a central role. Freud's posited the concept of signal anxiety and described psychological defenses that operate to diminish dysphoric affects, assumed to arise from the inevitably conflicted nature of the human mind. When utilized in the psychotherapy of psychosis, CBTp

techniques can be viewed from a psychoanalytic perspective as an enormously skillful elaboration of the psychoanalytic "observing ego."

Primary process is said to be "primary" in that it reflects the earliest form of limbic-based, affectively charged mental processing in mammals, before the neocortex evolved (Panksepp, 2005). Primary process relies on symbolic connections and figurative language (metaphor and simile) to make associative connections between things that are essentially different. For example, when George Orwell wrote, "Advertising is the rattling of a stick inside a swill bucket" (Orwell, 1956) he made a figurative connection between hogs at their trough and consumers enticed to hunger for products they don't need. Propositions framed in primary process terms use sensory imagery that has emotional resonance—the rattle of a stick in a swill bucket summoning the hogs. In psychoanalytic theory, secondary process is a neocortical thinking process that evolved to fine-tune the relationship of human beings to objective reality by minimizing emotional distortions of the real world. Whereas primary process links objectively different things to express a meaning, secondary process separates things by narrowing descriptions of people and things to observable objective characteristics that set them apart from each other. In secondary process, advertising is not at all a swill bucket. (Note that the distinction between primary and secondary process somewhat parallels the distinction the renowned cognitive scientist Daniel Kahneman (2011) elaborates in his book, by the same title, between "fast" and "slow" thinking, respectively.)

Secondary process asks, "What precisely is this? What is its objective measure?" Primary process asks, "How do I feel about this? Is this feeling like anything I have felt before?" Mental life without primary process would be an emotional dead zone, while life without secondary process would be a survivalist disaster. Mental health lies in a balance between these extremes. As is true of mental life in general, psychosis reflects both modes of thinking. I try to pay attention to both primary process and secondary process when integrating CBTp and psychodynamic psychotherapy. Although the therapeutic alliance is central to the success of all forms of therapy, CBT brings secondary-process/reasonable mind to bear on psychotic symptoms. Psychodynamic clinicians do not avoid logic, but they come at psychotherapy from a different angle, intent on interpreting the figurative meaning of psychotic symptoms.

In my view, psychodynamic clinicians unversed in CBTp often interpret the unconscious meaning of symptoms prematurely, while giving insufficient attention to the patient's conscious psychotic experiences and the evidentiary chain the patient has arrayed in support of a delusion. Failure to focus on the patient's immediate conscious concerns may fail to engage the patient. CBTp technique can show patients that they have made a mistake (e.g., there is a bias in their thinking), but it is ill-suited to explore the array of symbolic meanings embedded in their psychosis.

Although the concepts are not quite identical, I regard the CBT concept of *schema* as a re-naming of the psychoanalytic concept of unconscious fantasy. The *schema* concept implies a conditioned pattern of *belief* acquired in childhood. In psychoanalytic object-relations theory, as developed by Melanie Klein (Klein, 1946) and subsequently elaborated by Otto Kernberg (Kernberg, 1976), the mind is undergirded by an array of unconscious fantasies in which mental representations of the self are linked with an emotional valence to mental representations of

psychological objects. These mental representations are connected by links of emotion rather than conditioned beliefs. When I listen to a psychotic person, I try to discern the unconscious object-related fantasy that underlies the narrative expressed through the psychotic symptom. For example, the woman who believed herself to be the Bride of Jesus preserves a mental representation of her virginal self, betrothed to a loving groom in a marriage sure to succeed because it is sanctioned by heaven. Yes, she is literally mistaken when she claims her anatomy differs from that of other women, but her delusional story expresses her wish that she will someday be loved rather than violated, a fantasy that keeps at bay the unbearable sorrow of her ruined life.

Self-awareness is one of the more intriguing characteristics of human consciousness. Self-awareness allows us to be cognizant of our thoughts and feelings, but awareness itself cannot be observed (Deikman, 1999). The minute we become aware that we are observing ourselves, we immediately confront the question of who is observing that we are observing ourselves, and who is observing that we are observing ourselves observing ourselves, and so on, in an infinite regression of self-reflective mirrors that multiplies one's awareness of self.

The superego is an internal observer that floats suspended in self-awareness. Perhaps the single most common internal object therapists encounter with psychotic patients is the projection of a primitive fragment of the superego into a mental representation of a persecutory object outside the self that is thought by the patient to be observing the person—in Sean's case, the CoF. Patients often believe that strangers on the street are watching them, or that their houses or phones are bugged with spy devices, or that a computer chip has been inserted into their brain to monitor their thoughts. All such symptoms reflect the individual's feeling that they have lost the privacy of their minds and in their lives.

The ordinary self-reflecting function of the superego hypertrophies until it occupies much of the person's state of being. Human relatedness is reduced to the individual's relationship with his or her observer. In the above sense Sean's symptoms and the symptoms of patients like him who believe they are being observed involve the projection and personification of self-awareness, which in non-psychotic persons, is a basic attribute of normal consciousness. After the ego boundary is lost and the superego is projected, what in ordinary mental life would be "I am aware and I observe myself" becomes "They are aware and they observe me." (Deikman, 1999)

### *Outcome Considerations*

#### The Role for Writing About Cases with Limited Outcomes

The psychological literature contains many accounts of successful psychotherapeutic treatments of psychosis, including a number of excellent autobiographical accounts of treatment (Greenberg, 1964; Lauveng, 2012). I think it is important for clinicians to write not only about their successes, but cases with more limited outcomes. If psychotherapy does not succeed as hoped, it is incumbent upon the therapist to try to be articulate about why a psychotherapy progressed as it did, but no farther. I chose to write about Sean not to report his cure, but rather to examine some of the constraints that psychosis places on the psychotherapeutic process.



Although Sean is sufficiently stable to live in the community, he is as deeply entrenched in his psychosis as any patient I have encountered in two decades of psychotherapy practice. When I began working with him I hoped to help him but I also hoped to learn something in the process about the psychology of a seemingly intractable medication-resistant psychosis that might improve my work as a psychotherapist.

I try to paint a psychological portrait of how I imagine it feels for Sean to be alive. When patients fail to improve with medication, biologically-oriented psychiatrists speak of "treatment resistant schizophrenia," meaning resistant to medication. Because psychotherapy for psychosis is so undervalued, there is no comparable concept of "psychologically resistant schizophrenia." But psychological resistance is every bit as real as medication resistance. Sean exemplifies such resistance.

Psychotherapists need to think about the limitations of their methods to better define what needs to be improved. The last century has brought refinements in theory and technique in the psychodynamic treatment of borderline and narcissistic personalities (Kernberg, 1995; Levy et al., 2019) and has added a relational perspective to psychoanalytic work (Mitchell & Black, 1996). These refinements have been paralleled by the development within CBT of Linehan's (e.g., 2015) Dialectical Behavior Therapy (DBT) model of treatment. However, despite the contributions of many, psychotherapy for psychosis remains in the early stages of its development, in part because we have failed to achieve a critical mass of clinicians interested in doing this work in times dominated by the biological treatment of psychosis, a bias that sends research and treatment resources to the psychopharmacology ledger. In this case study I hope to say, "Here is the problem the patient presented. Here is how I thought about the problem. This is what I did. Here is the limited outcome I achieved and the barriers I encountered. What can be done differently? Where can theory and technique improve?"

### Some Outcome Context About My Larger Caseload

As mentioned above, I have myself treated over 50 chronically psychotic patients. While my integrated CBT and psychodynamic model has evolved over these patients, and I have not made a systematic attempt to evaluate outcome across these 50 patients, my clinical view of outcome across the patients provides additional context to the case study of Sean.

All the patients I work with had told their primary providers they were willing to engage in psychotherapy, which immediately introduces a bias in referrals toward patients amenable to psychotherapy. All the patients I have worked with were chronically psychotic despite years and sometimes decades of prior treatment. They all came to me as "treatment resistant" treatment failures.

If I had to estimate, I would say that of the 50 patients, roughly 20% made what might be called a near full recovery, meaning they ceased being hospitalized, developed insight into the psychology of their psychosis, and were able to work and maintain interpersonal relationships.

Roughly 70 % achieved substantial gains in the treatment marked by reduced anxiety and delusional preoccupation. It was sometimes possible to stave off inpatient admission and

medication increase with patients in this group when they had a psychotic relapse in response to a life stressor because having established a therapeutic alliance and having understood the psychosis in prior sessions, I was able to relatively quickly remind the patient about we had understood about their psychotic symptoms from previous work.

In 10% of cases I was able to establish a relationship but not able to achieve substantial gains owing to psychological resistances that emerged in therapy. For example, I am currently working with a man who believes he is a Russian spy who plays a pivotal role in world affairs. He has learned that he cannot talk to anyone about "what he does" because they will think he is crazy, so he lives a very lonely life. He never misses a session with me. In a way, he is like Sean because it would be crushing to realize that his grandiose identity was a delusion and he is in his early 30s with no real prospect of pursuing the life goals he had in his early 20s.

### Proof of Concept: The Case of "Silas"

When Silas was ten, he was raped by his uncle. Whenever his mother was very upset with him, she would strip him naked and drag him into the hall of their apartment building, then lock the door. Mortified with shame, he once went to the roof intending to jump. His father was a vain man who was never a supportive presence. Eager for a kinder family of his own, Silas married early, but his father teased him that he married *too* early, with insufficient sexual experience to consider himself a "real man." To gain his father's approval he had an affair, which he confessed to his wife. She stayed with him, but the affair destroyed all warmth and trust in the marriage for many years.

Silas became psychotic in his mid-20s, when he came to believe that colleagues at work knew that he had once deviated from company policy in a trivial way. He "saw" colleagues whispering about him and "heard" co-workers say "jail" and "prison boy." He believed that his co-workers were plotting to put him in prison, where he feared being raped, as he had been by his uncle. After eight years of pharmacotherapy, including a trial of clozapine which had little effect on his prison delusion, he was referred for psychotherapy.

In the CBTp phase of the treatment we considered his evidence for his delusion, and in classic CBTp fashion, raised doubts about his beliefs. Together we asked questions, including why would the authorities have waited to charge him until after the statute of limitations had expired? How could his co-workers, including new hires and people who had left the company, have kept a secret for 8 years? When Silas overheard voices coming through the walls of his apartment similar to what he heard at work, we considered what must the budget be for his surveillance if it required renting the apartment next to him and paying for a team to stay there. Easily millions of dollars over 8 years. When he once took a trip to London and heard the same voices next door and on the street as he walked through the city, we asked how could "they" have known where he was staying.

But even more to the point, how could anyone have known where Silas would be walking in the city, when he himself didn't know where his stroll through the streets of London would take him.

At one point he believed that I and his prescribing psychiatrist were in league with the authorities who planned to arrest him. This belief surfaced in a session in which he was particularly despondent. He spoke indistinctly with long speech latencies. Risking all on the

working alliance we had built in the previous 6 months, I leaned toward him and caught his attention. In a deliberate tone, I assured him that I had no relationship with his co-workers, but that if I did, that would make me a terrible person, a monster who had deceived him while maintaining the sham of trying to help. And I went on that if this were true, though it was not, he should cease contact with me immediately. I told him that if I had done what he imagined, I would have grossly violated my oath as a doctor as well as the HIPAA standards of confidentiality, which would lead to the loss of my medical license, a \$250,000 fine, and the ruin of my professional and family life. He had sufficient observing ego to consider that it seemed unlikely that I would risk all to conspire with his co-workers. By the end of the session, he seemed more animated and agreed to an extra session in 3 days.

In that extra follow-up session Silas revealed that the week before he had been actively contemplating suicide, seeing no other way out, but now felt that he had stepped back from the abyss. Early in treatment he had alluded to having been an abused child, but he declined to discuss it. I reminded him of his love for his wife and how devastated she would be were he to take his life, and told him that given how suicidal he had felt recently, he might need to talk about his abuse as a child in order to save his own life. This he did, for the first time in treatment. Thus began the psychodynamic phase of his treatment. In a succession of painful sessions in which he recounted his chaotic upbringing, he re-connected with his anguished childhood conclusion that his mother could not possibly have treated him with such cruelty unless he deserved to be punished. This feeling of badness evolved into his adult fear of being punished for a petty infraction at work, just as he had been many times punished for inconsequential "misbehavior" by his mother. The real crime for which he expected punishment was the affair, the desperate attempt of an abused boy to earn his father's respect. By understanding his own story, Silas made gains in psychotherapy not achieved with medication (Rathod et al., 2008). He no longer expected to be arrested, made additional progress repairing his marriage, became an active member of his church, and took joy in fathering his first child, a daughter.

Also note that in my book (Garrett, 2019) on my integrated cognitive-behavioral and psychodynamic model, I describe a number of patients, three in great detail ("Ariel," "Asha," and "Kasper"), who showed significant progress in an integrated CBT plus psychodynamic treatment.

#### **4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY**

##### ***Sean's Background and Core Delusion***

Having prepared the field, we now return to Sean, noting that some of the assessment information about his condition and situation has been provided above. In sum, at the time of presentation for therapy, Sean was 37, the youngest son in a large Irish-American family. In his early 20s he developed a chronic psychotic illness, with inability to work for any extended period and 10 subsequent inpatient psychiatric hospitalizations. While he had taken multiple psychotropic drugs over the years, which helped him remain calm and to be sufficiently well-organized to live in the community, they had no impact on his core delusion about a group of older men he calls the Counsel of Four (CoF) who persecute him. To remind the reader of details about the delusion, here is a quote from section 2 above, "The Patient":

Sean believed that the CoF operate a machine that can read his mind to monitor his thoughts for evidence of disrespectful sentiments toward them. On Monday morning they send him a Morse-code-like message which he discerns in sequences of automobile horns and bird chirps. They indicate whether his thoughts and actions merit a decision to discontinue their surveillance. Three beeps indicate he has not passed muster, and the surveillance persists. One beep would indicate that they will "let me out." Sean believes that the CoF also control robot birds that have the appearance of ordinary creatures but are actually machines that participate in observing him and sending messages to him. He believes that the machine that monitors his thoughts broadcasts on a live, video-feed reality television show that is watched by millions of people, which he takes as an indication of his potential business partnership with the CoF. As he puts it, "There are millions of dollars on the table." He believes that when the CoF are satisfied that he has been sufficiently respectful, they will include him in a lucrative book and movie deal about his life that will make him rich. At that point he intends to move to Los Angeles where, decked out with his new fame, fortune, and wealth, he will begin dating the movie star Megan Fox. Sean was preoccupied with these concerns to the exclusion of almost all unrelated mental life or physical activity.

### *Was Sean a Fitting Candidate for Ambitious Psychotherapy?*

The single most important condition for outpatient psychotherapy of psychosis is the patient's posing no risk of violence to himself or others. Although suicidal ideation is certainly not a contraindication to ambulatory treatment, nothing useful can happen in psychotherapy if the therapist is afraid for his or her property or person. Potentially violent individuals can be helped in an inpatient or partial hospital setting when treated by a team, but not in a solo office. Sean had no history of violence. But his having been quite ill for 15 years, with no significant periods of functional recovery despite expert pharmacological treatment (including clozapine, which is considered the gold standard in pharmacotherapy-resistant schizophrenia) cautioned a guarded prognosis. His reluctance to elaborate on what he was saying seemed a likely limiting factor in an ambitious psychotherapy.

On the more positive side, his willingness to attend sessions voluntarily suggested he might have some need for a conversation or be hoping to get something from the therapist. When patients make an appointment at the behest of a family member or another interested third party, there is often too little momentum to drive the psychotherapy process. In contrast to psychotic individuals whose delusions have an ever-shifting content, Sean's delusional ideas had condensed into an enduring psychological structure that might hold still for analysis over an extended period. I once worked with an African-American man whose family history changed from day to day. On Monday he was the only child of a wealthy Chinese family. On Tuesday, he was the sole survivor of a large Italian family. And so on. His mind was too given to shifting sands for psychotherapy to gain a foothold. Sean, in contrast, was intelligent, if not highly educated. He had a stable living situation and supportive family. He had not been hospitalized in many years.

When I accompanied him back to the clinic waiting area where his mother was waiting after our first session, the warmth of their mutual affection was apparent, with a slight twist. In a manner showing more confidence than he had in our sessions, he impatiently urged his mother out the door with a brusque, "Come on, Ma! Let's get going!" He was in command, and his

mother took no offense at his tone. One might easily have thought that he was accompanying his mother to her appointment rather than the other way around. Having gotten to know his mother a bit over time, I can see that her reticence to assert herself with Sean did not likely come from a passive character, but rather from her feeling at a loss about what to do or say to help her son. Sean was to use this "Come on, Ma! Let's get going!" tone with me from time to time with me in psychotherapy.

Finally, when I evaluate new psychotic patients, if there are no contraindications and if they have found their way to my office door by whatever conveyance, I am inclined to give psychotherapy a chance. This attitude was memorably reinforced in me a decade ago, when I began working with a man who had been hospitalized for 15 years in a forensic hospital after murdering his family. Although he would seem anything but a good prospect for psychotherapy, his treatment was ultimately successful (Garrett, 2019). For the first time, he was able to accept responsibility for the deaths of his family members and achieve sufficient insight to be discharged from the hospital. Without his determination to face his past, and without the opportunity to do so in psychotherapy, he would certainly have died on the gothic ward where he had spent most of his adult life. Many of my patients come to me through the determination of mothers who refuse to give up on their children. I try to stand with them. One cannot always predict what will happen in psychotherapy, whether with a non-psychotic or psychotic person, so the best way to find out is to give a try.

## 5. FORMULATION AND TREATMENT PLAN

A treatment plan should be grounded in a formulation, and a formulation grounded in theory. As I have described in more detail (Garrett, 2019), I have come to think of psychotic experience as an amalgam of three different streams of conscious awareness (See Figure 1). I use this model when formulating my approach to individual patients. First, people with psychosis may experience changes in their perception of the outside world. For example, in the common psychotic symptom of *ideas of reference*, a person may perceive events that would ordinarily hold little significance as having a compelling personal meaning; i.e., a psychotic person might say, "I can tell by the way strangers look at me that they know about me. Clearly, I am under surveillance." Sean believed that he was being observed in a reality television show by a national audience. In neurophysiological terms, psychotic persons may have a *hyper-salient* experience of ordinary events (Kapur, 2003).

Second, there may be an alteration of the conscious experience of mental events, such as thoughts, feelings, and memories, accompanied by a diminished sense of the self as the first-person "I" at the center of experience, along with a hyper-reflexive self-awareness of one's mental processes (Sass & Parnas, 2003). Instead of being a fluent actor and thinker, the psychotic person becomes an *observer* of his or her mental processes. Just as the objective outer world may light up with hyper-salient significance, mental events in the subjective inner world take on a hyper-salient patina that presents the psyche to the self as though it were an observed object rather than a fluent stream of consciousness. For example, a non-psychotic man might experience his ruminative self-critical thoughts of being "a loser" as *in his mind* whereas a psychotic man may "hear" a critical voice devaluing him, experiencing the voice as being

outside the psychological boundary of the self. In Sean's case, his mental life lacked the sense of privacy we all take for granted in our subjective inner worlds of thought and feeling. In the psychoanalytic literature, this absence of a partition between inside and outside has been termed a loss of "ego boundaries" (Federn, 1952; Tausk, 1988). Confidence in the privacy of our own psyche is a cornerstone of social relations and civilization. Unless we are overrun by emotion, it lets us say what we want to say and not more. As Bob Dylan sang in *It's All Right Ma*, "...if my thought-dreams could be seen/They'd probably put my head in a guillotine."

Third, psychotic individuals create a story to explain their life experience and the alterations of perception and changes in their self-experience, a story that the wider community regards as a delusion. For some patients, alterations of perception are a central theme. For others, changes in self-experience are more prominent. Sometimes a primitive internal object-related fantasy takes center stage. Often these three elements mix in varying combinations. Delusional narratives have a cast of characters (persecutors, victims, voices, messiahs, gods, and devils) that are fashioned from primitive internal object-related fantasies that are present in the minds of ordinary young children. These fantasies are brought to consciousness later in life by adverse life events, such as neglect, physical abuse, and sexual abuse, or in individuals who have a particular genetic vulnerability to psychosis and for whom the inevitable stresses and strains of ordinary living compound a thousand paper cuts that cannot be borne.

The delusional stories that psychotic people tell to explain their circumstances generally depict separate characters interacting in a story that can be viewed as an autobiographical play staged in the real world. The story has a figurative allegorical meaning. Although the characters in the delusion appear to be separate individuals, they are mental representations of the patient's mind, arrayed in a story that express the patient's personhood and regulates his or her psychic life. There are three main characters in Sean's autobiographical play: himself, the CoF (a poorly differentiated composite of 4 nominally separate individuals who observe him, as might the compound eye of a fly), and Megan Fox .

Stories have characters with whom the reader or listener can identify. When we identify with a character in a story, we feel either that the character is like us in some way, that the narrative in the story touches the narrative of our own lives, or we feel that the character is not at all like us, in which case we repudiate common ground. Stories allow us to identify our sympathies with some characters in a story and forestall our identification with others, allowing us to imagine that we share a fate with whomever we chose to identify with. In a classic story of the battle between good and evil, most listeners/readers identify with the good guys or those who have been harmed by injustice, hoping that the bad guys will in time be punished. Even when a good character comes to a bad end, the audience takes some comfort in knowing that although a calamity befell someone like themselves, tragedy did not befall them personally. Delusional narratives are a kind of allegorical story.

Here is a non-psychotic example. In Aesop's fable of the fox and the grapes, the hungry fox comes across grapes hanging high on a vine. Initially, the fox's mental representation of the grapes depicts them as luscious. But when he cannot reach the grapes, the fox changes his story by altering his mental representation of the grapes.

Feeling hungry, angry, and taunted by the grapes he cannot have, the "good grapes" become, in the fox's mind, "bad grapes" not worth desiring in the first place. The fox dials down his sorrow by revising the narrative to read, "I have lost nothing because there was never anything to gain in the first place." Unrequited desire is inevitable in life. Readers can reflect on the dilemma of unrequited desire by identifying with the fox ("I have wanted things I cannot have") and they can distance themselves from the fox ("The fox is the sad, hungry, frustrated one, not me") while considering more adaptive solutions to this universal human problem. In Sean's autobiographical play, he gains the respect of his elders, achieves fame and fortune, and gets the girl, a tale in stark contrast to the constraints of his actual life.

Just as non-psychotic people can be gripped by a novel, a play, or a movie, where they identify with actors in the play by projecting parts of themselves into different characters in the story, people with psychosis create characters in delusions with whom they can identify to express their troubled life story, though in an encrypted manner.

Just as a non-psychotic movie-watcher may identify with a character in a film who eventually celebrates a happy ending, psychotic persons construct characters and plot lines to escape from the painful reality of their lives. Delusions do not have a happy ending in real life, but they do translate intrapsychic problems into an imagined interpersonal conflict that focuses on elements in the outside world rather than the person's inner turmoil. Sean forfeited the entirety of his young adult life to his psychosis. He shields himself from this ghastly reality by imaging a happy ending to his tale, in which he gets a book and movie deal and marries Megan Fox .

Clinicians should aim to develop, and over time refine, both a *working CBT formulation* and a *working psychodynamic formulation* of the patient's psychosis which together help guide treatment.

### ***The Working CBTp Formulation***

In the linear A-B-C cognitive model, which I prefer to the more recently evolved CBT triangle of thoughts, emotions, and behaviors, because its simplicity lends itself to work with psychotic persons, "A" is a triggering event that activates a cognitive sequence; "B" is a belief about the personal meaning of event A; and "C" is the emotional or behavioral consequence of that belief. In the case of an idea of reference in which the glance of stranger is perceived as evidence that one is under surveillance, the "A" is the glance, the "B" is the belief in surveillance, and the "C" might be a mixture of fear and anger, possibly accompanied by behavioral avoidance or pre-emptive strikes against the perpetrator.

A mundane illustration of this sequence in a non-psychotic person would be: You call someone's cell phone, and he or she doesn't pick up (the activating event A). Alternative beliefs (B) might be that the person is in a cellphone tower dead zone, or the person's need a new phone, or the person inadvertently turned the phone off, or the person is ducking your call. The emotional and behavioral consequences of each of these beliefs (C) would be different. If you have suffered a childhood adversity that leaves you with a predisposition to believe that the person you called is avoiding you, that expectation might press into consciousness as a

psychological symptom in the form of a rumination about either the injustice of the rejection (a story in which you are the victim) or the justice of your rejection (a story in which you deserve to be rejected). A similar thing happens in psychosis, wherein underlying anxieties and painful affects linked to adverse life experiences erupt in a theater of the mind. Disturbances of perception and self-experience alter the contours of consciousness in the form of anomalous experiences that break with consensual reality and are bound in a delusional narrative. Consider the analogy of a volcanic field of strangely shaped forms of cooled igneous rock. The lava shards are the enduring surface (conscious) residual of pressured underground (unconscious) forces that instigated the eruption. CBTp techniques lend themselves to chipping away at the magma that has hardened into a persistent psychotic symptom; psychodynamic techniques provide tools to explore underground chambers that are still affectively hot.

In working a CBTp formulation, the therapist aims to identify what conscious symptomatic outcropping of the patient's mind might offer a promising first focus for CBTp work. Where to start? Although there is no cookbook guide, the following can be considered when planning a CBTp point of entry into the psychosis.

All forms of psychotherapy aim to reduce suffering. From the patient's point of view, what is the primary source of the patient's distress? For patients whose suffering is acute (which is not always the case), this is an apt place to begin, lest the patient believe the therapist is turning a deaf ear to their distress. For example, for patients who hear voices, the derogatory content of the voice is often a primary source of distress, and therefore a compelling first focus for treatment. In contrast, patients who hear a supportive voice they believe to be that of God may not consider the voice to be a problem, but rather might find their family's refusal to accept that they are talking to God to be a major source of distress.

1. The therapist might start by teaching the patient the A-B-C CBTp method by examining a mundane everyday event that offers multiple alternative explanations, as in the cell phone example above.
2. On occasion, the therapist intuits that some particular alteration of perception or self-experience is, in the patient's mind, a key event in the evidentiary chain the person has constructed in support of the delusion. Descriptions of such particulars are often phrased as, "It all started with ..." or "That's when I knew ..." For example, a woman whose marriage was failing, and who was also undergoing a crisis of professional identity, noticed that the paint she had used to paint a portrait appeared to have been altered overnight. This observation ushered in her belief that a group of psychologists were testing her reactions to changes in her environment to determine whether she was better suited to be an artist or whether she should pursue a business career.
3. Even when patients are quite convinced of the truth of a core delusion, they may have doubts about some aspect of their psychotic experience. For example, a man believed that entities entered his body at night while he slept and had sex inside his body. It struck him as odd that given the size of an adult person, he did not see scars on his skin marking their points of entry and exit. When patients have pre-existing doubts, the therapist can help them to use the A-B-C CBTp method to explore alternative explanations for their anomalous experiences.



Then, once they are practiced in the CBTp method, the therapist can move on to beliefs that are more difficult to challenge.

4. The therapist may start with a belief that most easily lends itself to challenge, in the hope of extending doubts generated about this particular belief to other beliefs by saying, "If you were mistaken about this one belief, might there be others where you have come to a questionable conclusion?" In Sean's case, I chose to start with his belief that there was a machine that could read his mind, because I knew I could marshal clear evidence that there is no such machine.
5. The therapist should be sure to address potential threats to the therapeutic alliance, such as a patient's belief that the therapist has been accumulating information to justify re-admission to the hospital, or assuaging doubts a patient might have about the privacy of sessions. At times when patients are struggling with a real-world problem, such as the lapse of their Medicare or Medicaid benefits, it is important to help them solve whatever concrete problem preoccupies them.

### *The Working Psychodynamic Formulation*

Unlike the summary above of a working CBTp formulation, there is no need, nor could one even attempt, a similar summary of psychoanalytic theory and technique that would fit within the space of this case study. I must assume that readers have some familiarity with psychodynamic ideas and skills. The psychology of psychotic and non-psychotic persons is similar in many respects. Psychotic persons have the same needs as do all people, as summarized in Maslow's concept of a 5-tiered pyramid—physical needs for food, clothing, and shelter; security of body and property; love and belonging; self-esteem; and self-actualization. Harry Stack Sullivan's version of basic needs postulates that in the course of growing up, all people need to achieve sufficient social skills to guarantee "satisfaction" and "security" (Sullivan, 1974). By satisfaction, he meant meeting basic needs for body satisfactions, including food, shelter, and a sexual life. Sullivan's satisfaction overlaps Freud's concept of libidinal drives. By security, he meant a secure standing in one's community that affords meaningful work and provides self-esteem. In Sullivan's view, failure to achieve sufficient social competence to ensure satisfaction and security invites schizophrenia. The therapist aims to understand how the delusional narrative is a disguised recollection of adverse life events that have derailed the person's attempts to achieve satisfaction and security by ordinary developmental means, and how the delusion attempts to diminish the distress of this failure and achieve satisfaction and security in illusory ways.

Psychotic people have the same basic conflicts as do all people, with the exception perhaps of annihilation anxiety, which may be unique to psychosis (terror of the disintegration of an integrated self), and alterations of self-experience (diminished ipseity and hyper-reflexive self-awareness) that may be pathognomonic of psychosis (Louis A. Sass & Pienkos, 2013). In my clinical experience, spirit-witheringly poor self-esteem is the most common psychological driver of delusional narratives. People who break down in psychosis in adolescence and young adulthood feel themselves to be failures in life. The majority of psychotic persons hear voices, and the most common voice reiterates the person's worthlessness. Voices commonly express the

patient's self-hatred, which began in childhood, when adverse experiences led to their feeling worthless, a self-loathing compounded by a failure to achieve expected developmental milestones. Psychotic persons must contend with intense feelings of terror, rage, grief, guilt, shame, and envy. Conflicts over sexual desires and aggressive impulses are also ubiquitous. Delusional narratives are meant to express intense affects and contain them. For example, the central theme in Sean's delusional narrative of the CoF is guilt. More about this presently.

Human beings are natural story-tellers. We describe ourselves and our reality in the form of stories. For example, when doing chemistry, we may say, "Hydrogen bonds with oxygen to form water." This is a story of how one thing attaches to another, a narrative easily understood by a child who has built a structure by attaching one Lego piece to another. But the "hydrogen bonds to oxygen" story in no way approximates the image of water revealed by quantum physics, which speaks of electrons and protons as probabilities quite unlike the physical solidity of Lego pieces. The equivalence of mass and energy, the Heisenberg uncertainty principle, and string theory are harder to express in a story that mimics the macro activities of everyday life. Delusions are stories that have a meaning, however inaccessible they may seem at first pass. The psychotherapist forms a working psychodynamic formulation by listening to the story the psychotic person tells, in the same way one would listen to anyone telling a story, whether in person or in a novel or a film, to discern the underlying theme(s) expressed there. Small children know what the story *Charlotte's Web* is about. So do their parents. No advanced psychoanalytic training is required. What is required of therapists is to believe that the patient's delusional narrative is a story that has meaning and that it is the therapist's job to try to discern this meaning.

## 6. COURSE OF THERAPY

### *Getting Started: Establishing a Therapeutic Relationship and Starting to Work on Sean's Delusionary System*

Sean was perhaps more comfortable in our initial meeting than he might have been otherwise because my office is down the hall from the suite where he had for years seen his psychopharmacologist. He was neatly dressed in a fashionable print shirt and jeans. His brown hair, tinged with a natural dusky red, was close cropped. His beard, also tinged with red, cast a 5 o'clock shadow at his 10 am appointment time. I smiled and said hello. He said hello, and slid into the patient chair at the far end of the rectangular table at which I work. He looked slightly down and away. In our first session I took a history of his psychiatric treatment as noted above. As we talked, he appeared to be preoccupied with an internal stream of thought, but he did not seem to be responding to hallucinations. He was able to give short answers appropriate to my questions, though he took little initiative in the conversation. As we talked about his history, such as he could describe it, I sketched on a large-sized paper a timeline of his life that followed his illness from its onset in his early twenties. Many chronically psychotic persons are unable to construct a coherent narrative of their lives (Lysaker & Lysaker, 2009). Seeing their histories on paper can help some patients see connections between life events that they cannot appreciate simply by reflection. He said he was "bipolar." He did not consider his relationship with the CoF to be a manifestation of his bipolar illness or of any other medical condition. The CoF was the

focus of his life. I asked him to tell me about the CoF.

The CoF appeared seemingly without warning 8 years ago. The Council consisted of four men, Mr A, Mr B, Mr C, and Mr D. He recalled nothing in particular that was going on in his life at that time that could provide a "why now" clue to better understand their arrival. This was unfortunate because, as is true of all psychological symptoms, an understanding of the precipitant of a psychotic symptom is often a window into its meaning. He remarked with some irony, in the tone of an upset child baffled by a disappointment, that at first his surveillance was supposed to be "a joke" that he expected to last only a short time. But the "joke" had now persisted for many years.

Every Monday for 8 years the CoF had sent him a message via automobile horns/birds indicating whether his thoughts and actions in the past week had been free of disrespectful thoughts. After his eventual release from surveillance, he expected the members of the CoF to invite him to be business partners with them in a lucrative movie/book deal.

In Sean's case, a *psychodynamic working formulation* was immediately fairly obvious. Sean's delusion is a psychotic oedipal story in which he is under the constant surveillance of four older father-figures who pass judgement on all his thoughts and actions. That surveillance is broadcast nationwide in a live video feed. Unlike the Greek Oedipus, who was punished for his desire for his mother by the loss of his eyes (a symbol of castration), the CoF never threatened Sean with bodily harm. Rather, they withheld his adult life from him, as if to say, "You are not free to pursue love and work on your own. You are not entitled to the pursuit of happiness. Only we can grant that privilege." In this rendition of the classical myth, the father withholds or dispenses to his son, as he pleases.

Over time, I came to understand a particularly poignant aspect of Sean's dilemma. Not only did he want money (the book/movie deal) and sex (Megan Fox), as might many young men, but he also wanted the love of the CoF and an ongoing warm relationship with them. He did not wish to do anything or think anything that would jeopardize the future affectionate tie he envisioned with these men. He struggled mightily to endure his suffering without getting angry at the CoF, because if he were to feel angry, the CoF would know what he was feeling via the machine, and his prison sentence would be extended yet another week. He envisioned the end of his travail as his being welcomed into a trusting business partnership with the CoF. As Sean was apt to say, at moments when his suffering was about to surface in his mind in the form of a complaint about the CoF, "They are good guys, once you get to know them." Absurd as this description of his tormenters was on the surface (his tormentors are "good guys"?), it showed me how he thought of the CoF as he knew them in his daydreams about his future.

I want to emphasize the careful choice of words and loving tone of voice in which Sean spoke of his persecutors. It required little imagination to see Sean's attitude toward the CoF as the sentiments of a boy who feared his father and craved his father's approval and love. Psychotic people have relationships with their voices and other projected figments of their minds (Benjamin, 1989). Although biology likely played a role in the particular form in which Sean's autobiographical play came about, the CoF was not a meaningless fragment of mental life inserted into his brain by an aberrant genetic allele (variant). Rather, Sean's delusional narrative

was his version of a universal story of love and lack of love between fathers and sons. Unlike a Maasai boy, who in times past had to kill a lion to become a man, Sean had to endure his suffering without complaint, in the manner of a saint, until he achieved a purity of mind devoid of any "disrespectful" thoughts toward the CoF. He lived with the dream of becoming a man some Monday morning, when the automobile horns fell still.

In the first several sessions I took a history. I sketched out on a piece of paper what Sean and I came to call his "guilt loop." The loop began with his thinking a thought or performing an action, which the observing machine would record and transmit to the CoF. His thoughts and actions were simultaneously broadcast nationally. When the CoF detected a thought or action, they would send him a message, conveyed in a particular rhythmic cadence of automobile horns, often right after he had had an offending thought, and always on Monday morning, as a dreadful report card for the week. He always received a failing grade. The horns played a central role in his psychosis. In the model in Figure 1, the horns exemplify the changes in the first column, that is, an alteration of perception that is given a delusional elaboration in the psychosis. Sean "heard" a message where no one else did. Framed as an A-B-C CBTp formulation, the horns are the activating event "A," his belief "B" is that three beeps means the monitoring remains in place, and the consequence "C" is fear, guilt, and social isolation. Although the horns would have to be addressed in the therapy, in my CBTp working formulation I decided to start with the machine that can read his thoughts rather than with the horns. I did so for four reasons.

First, the machine was an integral part of Sean's delusion, without which the guilt loop could not operate. Second, there were limits to his belief about the machine that suggested islands of reality testing that might be mobilized in the treatment. He did not believe that he could read minds, or that I could read his mind, or that the online audience could read his mind, which suggested that there was a line beyond which his delusional conviction did not extend. Third, unlike the altered-self experience of his mind lacking privacy or the hyper-salient experience of the horns, which entail altered subjective states rather than a belief per se, his sentiments about the machine more closely approximated a simple belief conjured up to make his story work. It is hard to resist the temptation to call his mind-reading machine a *deus ex machina* that Sean required to preserve the credibility of the delusion. And fourth, since the capacities of brain imagining machines such as CT scans and fMRIs are objectively known, I thought this might provide leverage to raise doubts about the delusion.

I thought that Sean's belief that his mind could be read explained to himself and others the altered state of subjectivity in which he had lived since the advent of the CoF. Because descriptions of subjective experience depend upon an individual person's report of an inner state of mind that cannot be observed and corroborated by others, as Spitzer (1990) has argued persuasively, the term "delusion" proper might best be reserved for statements that can be objectively falsified against a backdrop of consensual reality. CBTp's emphasis on cognition without a comparable emphasis on the lived subjectivity of the psychotic person (the phenomenology of psychosis) marks a limit of CBTp technique (Skodlar, Henriksen, Sass, Nelson, & Parnas, 2012). Although almost any condition can be framed as a belief statement, as in "You believe that your mind has no boundaries," to speak of the *mind-reading experience* as a belief transforms what is fundamentally an altered state of consciousness into a proposition,

something that it is fundamentally not in its lived experience.

For example, a man's claim that a computer chip has been inserted into his brain that can read his thoughts can be objectively falsified with brain imaging studies. Neural implants are part of modern medicine, but implants are not absorbed by the patient's brain substance. They appear on a brain scan as a place of whose density contrasts with the surrounding brain tissue. If Sean were to have said, "I feel as though my mind is being read," we would understand this as a figurative metaphor meant to describe his state of consciousness. No one would think to say, "No, it is not true that you feel this way. That is a delusion." Instead of speaking in figurative metaphor, Sean speaks in a concrete metaphor that does not say he *feels like* someone is reading his mind but rather that his mind *is* being read. If he were to assert that I could read his mind, this statement would be objectively false. I knew no such machine existed, but I believed his statement indicated an altered self-state that was subjectively quite real. Therapists working with psychotic patients would do well to distance themselves from the familiar binary dichotomy, "Is it true or is it false?" and instead see the patient's delusional assertion as at variance with consensual reality, but nevertheless subjectively true. After all, when we report a dream to another person we do not say, "Last night I imagined a dream." We say, "I had a dream," giving the dream the full force of subjective (psychic) reality.

Back to Sean. Another patient might have said, "I feel like my mind is being read, but I know that can't be true," which would be an example of "double bookkeeping" in psychosis, where opposites are simultaneously entertained (Louis A. Sass & Pienkos, 2013). Sean's belief about the machine did not reflect simultaneous opposites but rather a circumscribed split in his mental representation of the outside world. No one, including the CoF, could read his mind without the aid of the machine. His understanding that people can't read each other's minds was a vestige of his pre-psychotic reality in which he experienced his mind as private. Were he to believe that I could read his mind, as some patients do, this would have rendered psychotherapy extremely difficult. Believing that one's mind is private is a developmental achievement. Very young children believe that mother knows all and are delighted to find by age 4, 5, or 6 that they have the capacity to lie. Acutely psychotic patients who are too disorganized to restrain what they do or say develop a semblance of recovery when they regain the capacity to lie to inpatient staff. When asked, "Are you still hearing voices?", a hospitalized patient who continued to hallucinate might say "No," because this lie offers the best chance of discharge. The patient tells the clinician what the clinician wants to hear, secure in the newly re-established privacy of the patient's subjectivity. In a touch of irony, during the very discharge interview when the patient asserts that he or she no longer hallucinates, a wily voice may tell the patient "Say no!"

In one session early in treatment I outlined the "guilt loop" on paper and drew attention to the machine. I asked him how he knew of the existence of the machine. At first, he sidestepped the question. In a tone of voice meant to settle any doubt, he said, "Doc, that's how they do it!" Like a tennis player who wanted to finish the match with one dramatic volley from the net, Sean wished the point to be over, in his favor. In work with non-psychotic and psychotic persons alike, the therapist is often called upon to hit the ball back over the net to keep the conversation going.

Psychiatric residents-in-training have difficulty doing this, in part because they don't want to put patients off by challenging them, and also because early in their career they have only a few things they are confident in saying to patients. So, when their first intervention is turned away, they tend to back off. There is a balance in working with psychotic patients between allowing the patient's defenses to operate unfettered, which does not forward the therapy, and badgering the patient about a point, which does not enhance the therapeutic alliance.

I hit the ball back over the net to Sean. "Sean, I know you believe there is a machine that reads your mind. I am asking you a slightly different question. Here it is again. How did you come to this belief?" He returned my lob to his back court, still strident, but with a slight shift in focus. In a tone that suggested I was a bit naïve, he said, "It's on the internet. I've seen it on the internet. Everyone knows about the machine!" I said, "If it's on the internet and everyone knows, we should be able to find the machine on Google and check it out. Shall I research it and tell you what I found next session?" He had never done such a search because he did not need external corroboration of his belief.

He knew it to be true because he was the author of his autobiographical play, and the machine was essential to his plot line.

I started the next session, approximately 6 weeks into treatment, "I researched the machine this week, as I said I would. I am a psychiatrist, and I also have training in neurology [intentionally pulling rank as an authority in a casual manner rather than an authoritarian tone], so if there were a machine that could read thoughts, I am pretty certain I would know about it." I showed him a site on Google where several fMRI scans were posted in color and invited him to swing around the table to look at the computer with me, which he did. I asked, "Is this the sort of brain machine you were talking about?" He said yes. I then explained to him that he was right that machines like the one we were looking at could show that there was brain activity occurring in one area of the brain or another, but an fMRI machine could not tell what a person was thinking. I asked him if he could tell what the person in the fMRI scan we were looking at was thinking, and he said no.

I told him there was another kind of machine called an EEG that sensed brain activity. I brought up an example of an EEG tracing on my computer, and asked if he could tell from the squiggled line what the person was thinking. He said no, but fell back to his default position. "It's real Doc. The CoF really have a machine." I countered, "I guess we will have to leave it there for today. The machine you are talking about would have abilities far beyond modern science. As a psychiatrist and neurologist, I think I would know about such a machine. Its inventor would surely have won the Nobel Prize. OK. Let's continue next week." Thomas Dolby's lyric, "She blinded me with science" floats through my mind now as I am writing this, but not then as he left my office.

Therapists rarely, if ever, help patients distance themselves from the ligatures of a delusion by winning a carefully crafted logical argument. In the autobiographic account of her psychosis, Joanne Greenberg (1964) describes a substitute psychiatrist who saw her when her therapist, Frieda Fromm-Reichman, was away for an extended period. He used logic to show her that the private language of Yr that she cherished in her delusion was a derivative of words she

already knew before her psychosis. This smarty-pants logician won the logical day but lost the therapeutic alliance.

I did not intend to win an argument with Sean about whether the machine existed or not. Rather, I wanted to stake a claim that would engage him without my being summarily dismissed. Many psychotic patients are not the least interested in what the therapist has to say. More commonly, psychotic individuals feel that no conversation is possible unless the therapist thinks as the patient does. Differences of opinion are not tolerated. Melanie Klein wrote about this form of transference as the wish of the patient to enter into the therapist's mind and control what the therapist thinks (Klein, 1935, 1946). An independent mind and an independent point of view presents a radical threat to a psychotic person, who is impelled to maintain a mental representation of the world as he or she has created it to be. Said another way, in Kleinian terms, the paranoid-schizoid position, in which mental representations of other people are largely projections of parts of the self, is a single-author text. Sean was not convinced by my argument that there was no evidence for a mind-reading machine, but I expected that.

While he held his ground, I was heartened that he did not mount a determined counterattack. In effect, he agreed to disagree, I think because he valued the promise of our relationship more than he needed to win his argument. Sean was and is a very lonely man. He lives his life in a mental world that he shares with no one, psychotherapy being one exception in which he can find a companion.

What follows is not a month-by-month account of his psychotherapy, but rather an account of a number of themes and events that we explored in the course of his treatment. I present them roughly in sequence as they emerged in psychotherapy.

### *The Automobile Horns Every Monday*

We turned to the automobile horns that every Monday announce his standing with the CoF. A very useful CBTp technique is to "drill down" on the A that in the A-B-C sequence engenders a delusion; in Sean's case, his experience of the horns. In psychosis the A and the B are fused. The meaning of an event is immediately apparent in the moment of its perception. Karl Jaspers called this phenomenon "delusional perception" (Jaspers, 1963). Marcus (2017) speaks of a blending of reality experience and emotional experience. While psychodynamic technique attends first to the meaning of anomalous experiences, CBTp provides a technique to separate the activating event A from the delusional belief with which it has merged, so that the experience can be thought about differently in psychotherapy.

In the spirit of a request attributed to Jack Webb (the actor who played Joe Friday in the 1950s TV detective show "Dragnet"), the therapist wants to ask, "Just the facts, ma'am." The question is, what precisely did the person see or hear? For example, a patient claimed that his voices intended to kill him. When asked what precisely had he heard, he replied, "Take care!" His experience of the voice as a warning was fused with "Take care." When it was brought to his attention that the voice might have said "Take care!" as an expression of care at leave-taking, he acknowledged that as a possibility. Also, real events occur in an environmental surround with detailed particulars. Unlike hyper-salient perceptions, which tend to hover in isolation in a

strange, numinous mental space, real events do not float untethered without a reality context.

The therapist can forward the treatment by inviting the patient to look for the reality context that should be a backdrop to perception.

For example, a man reported that two strangers in his apartment lobby looked at him "as if they knew." The therapist might begin along these lines:

Have you experienced "knowing looks" ever since you moved into your apartment? Oh, so you haven't. I assume you look at strangers sometimes even when you know nothing about them? Yes, you do. Let's call that kind of a look an "ordinary look" of curiosity. In the past, before all this started, you experienced ordinary looks from strangers. Let's construct two columns. The first column we can label "a knowing glance," and the second column "an ordinary look." Can you tell me precisely how a knowing look differs from an ordinary look? I see. It is hard to describe. Oh, so it is more a feeling about the stranger's look than anything you can actually point to about the look so that I could see what you saw. It would seem that the knowing glance is a feeling you have, something that happens inside your mind, more like an emotion than a particular characteristic of another person's face. Which leads to the question, why do you perceive strangers differently than other people?

I used this tried-and-true approach to open up discussion with Sean about the horns.

When you were growing up, did you always hear messages in car horns? Oh, so this all started 8 years ago when the CoF came into your life. So if we make two columns, and on one side put the "old horns" that sent no message and the new horns that came later that send a message, can you tell me precisely how the sound of the old horns differs from the new ones? He deflected the question. "It isn't the how the horns sound. It's the rhythm. When the horns are coming from the CoF its three beeps, like this." He imitated a staccato Morse Code cadence, dot.....dot-dot.

From his perspective, he had described in detail how ordinary traffic noise (no cadence) differed from a message from the CoF. He offered little traction here, but I tried to salvage one point at least. I asked if anyone else heard the messages he heard. He said no. I said, "So I guess we can say that if I or anyone in your family was standing next to you and heard the same horns as you, you would hear a message but everyone else would hear random traffic noise." He agreed that this was the case.

In a subsequent session I invited him to explore why he might hear a message in the same traffic noise where others hear none. He said he didn't know, but reiterated, "Doc, this is real!" I asked him if he was interested in an idea I had about why. I often ask patients if they are interested in what I think. All but the least engaged patients will be curious. If the patient claims not to be interested in what the therapist has to say, that opens one door of discussion. If the patient says yes, if only to find out what the therapist is thinking to better refute the therapist's contentions, the therapist now has the patient's attention, which cannot be assumed always to be the case with psychotic persons. I said to Sean,

One thing that occurs to me is that to some degree we hear what we expect to hear. Everyone's mind and brain work that way. Sometimes I hear my name out loud on the street



where I am alert to someone calling me, and often there is no one there when I hear my name. I hear it because I expect I might hear it. That's the way people get my attention. Parents of newborns who are alert to the baby's crying sometimes hear the baby crying when the child is sound asleep. They hear what they expect to hear.

I asked him had he ever felt his cell phone vibrate when there was no indication of a message. He said he had. Linking psychotic phenomena to ordinary mental events is an example of the CBTp technique of "normalizing," which is not to say that psychosis is normal, but that one can find analogies to psychotic phenomenon in ordinary mental life. Having introduced the topic in one session, I saved the *pièce de résistance* (or so I hoped) for the next session.

In the next session, I invited him to watch a YouTube video with me, much as I had invited him to search the internet with me when we were looking brain-imaging machines. I introduced the video. "I came across a video made by a famous brain scientist that shows how we hear what we expect to hear. It's what we were talking about last week. Shall we watch it together?" I had used this video, made by the English neuroscientist Anil Seth, to good effect with other patients, including a woman who heard coded messages in the footfalls of her neighbors in the apartment above her own that she acknowledged her daughter did not hear. Here is the YouTube link: <https://www.youtube.com/watch?v=lyu7v7nWzfo&t=74s>

In the video demonstration Seth plays what at first appears to be a distorted sound with no discernible meaning, rather like an undulation coaxed from an electric guitar by a wawa pedal. He plays it again. Still no verbal content. Then he primes the listener for what to expect to hear by playing the message with less distortion, after which the listener clearly discerns a message in what was previously a nonsense sound. The take home message is that expectation can change random noise into a message. I won't reveal the message so as to not spoil the effect for listeners who want to experience it directly in Seth's talk. It is quite compelling. Once you have "heard" the previously nonsense sound as a message, there is no going back. The once ambiguous sound reliably conveys the same message each time it is heard. The same was true for Sean.

Once he heard a message from the CoF in the random traffic noise, he forever heard the same message every Monday morning because he expected to hear it. His guilt had conditioned his reception of a meaning. He followed the Seth demonstration attentively but concluded, "But that's not my situation. The horns are real, Doc." I did not expect to win the day with the Seth demonstration, but it established as a place-holder that I referred to from time to time in therapy. "Remember that video I showed you, Sean. It's just like that."

### *The Therapeutic Relationship*

Sean has never forgotten an office appointment and has never missed one, except for a solid reason. When he steps through the door into my office, he extends his hand, and typically says, "How are you, Doc?" I have a small espresso pod machine in my office. I once offered him a cup, which quickly became a tradition, one at the beginning of each session, and one as we were winding down at the end. Decaffe espresso, at his demand. When he brought a candy bar to a session, he would offer me a piece, which I always declined, begging off for weight control

reasons, but I always have a coffee with him.

Head at first down as he attended to his candy and espresso, he would presently look up and say, "OK Doc. Let's do some guilt work!" This phrase became the opening bell for each of our sessions, reflecting the understanding I had conveyed to him repeatedly, that however he thought about whatever was going on with the CoF, he suffered from enduring feelings of guilt, an observation he endorsed. Despite his speech latencies and preoccupation with inner streams of thought, he retained a good sense of humor. On occasions, with impeccable comedic timing, he would make a joke about something we had spoken about 20 minutes or more earlier in the session. He enjoyed teasing me, particularly about our schedule. When I returned from a 2-week trip that had interrupted our sessions, he joked with an ever so slightly edge, "Doc! Two weeks!? *One* week. That's OK. But two weeks? You're a doctor. You have patients. Two weeks is too much." He of course never said that he missed me.

### *Guilt Work*

The notion of "guilt work" became a leitmotif in sessions. Although it remained for Sean a general descriptor of what we were doing together, we made some progress in this arena. He was unable to consider that he need not feel guilty in relationship with the CoF, but he was able to identify and report to me occasions when he "felt guilty about stupid stuff." For example, one week his mother had asked him to take out the garbage, but he delayed doing it. He said this was "no big deal," but he felt guilty about it nonetheless. He recalled that when he was a boy, he used to rub snow in his younger brother's face. He felt guilty about having done this, but added "Kids do that. It was a long time ago. It doesn't matter now." These reflections allowed us to establish that before he became ill (he acknowledged having 'bipolar'), he experienced ordinary guilt inside his mind. Now, since the CoF had arrived, he experienced excessive guilt "outside his mind" in his thought that a national audience was following his ongoing trial in which the CoF sat as judges.

It was not until 4 months into the treatment that I understood the severe constraint that the "outside guilt" would impose on the psychotherapy. In a typical session, after his espresso and his invitation to "do some guilt work," I would ask him how his week had gone. He would often say, "It started out good and I almost had it [his dispensation from the CoF], but I blew it. I think maybe now they will end it next week." I would invite him to say more about what he had thought or done that had displeased the CoF, to which he would respond, "I'd rather not go into that."

Because he believed that the CoF were using the machine to monitor everything we were saying and doing in session, to repeat a thought or recall an action he thought the CoF might consider disrespectful was to flaunt his defiance in their faces, inviting more severe punishment. I said, "Sean, I know that you believe that doing guilt work is important, and I want you to know that I know how difficult it is for you, because if you tell me a thought or something you did that made you feel guilty, it feels to you like you are being disrespectful a second time." He agreed this is how he felt. I added, "I know you are doing the best you can, but I want you to know how your fear of saying too much limits what you can tell me, and therefore makes it harder for me to help you psychologically."

On some occasions he was able to take small risks in the guilt work. When he would tell me he had had a bad week, and I inquired why, he might say, "Maybe I will tell you something later, but not now." Sometimes this delay was enough for him to mention what he thought had given offense to the CoF. For example, after such a 20-minute delay, he told me that the CoF had not let him off that week because he had been thinking about a disco song he liked called "Shiny Disco Balls" that he thought offended Mr. B. When I asked why Mr. B might have been offended, he made clear that the "shiny disco balls" in the song had a testicular referent. I later researched the song, which is by a group called Who Da Funk. Here is one stanza.

Drugs and rock 'n' roll, bad ass Vegas hoes  
Late-night booty calls and shiny disco balls  
Drugs and rock 'n' roll, bad ass Vegas hoes  
Late-night booty calls and shiny disco balls  
Drugs and rock 'n' roll, bad ass Vegas hoes  
Late-night booty calls and shiny disco balls

Oedipal crimes indeed. No wonder Mr. B took offense. On other occasions he would allow me to inquire about some guilt-inducing event only if I promised him that I would stop talking if he told me to stop. I of course agreed, but on occasion when I pushed the inquiry too far, he would raise his voice, anger in his eyes, and say, "Shut up! I told you to stop. No more!" To protect him from the CoF, I would liberally mark what I said with phrases such as, "This is what I think. This is not what you are saying or thinking," as though I wanted the CoF to overhear that any blasphemy in the session was mine not his. This sometimes allowed us a little more room to talk, but he considered it his responsibility to not let me speak disrespectfully of the CoF. Twice in the 18 months we had been working together he called me during the week to say, "You really got me in trouble with the CoF!" I briefly became his persecutor. I was usually able to talk him down and reassure him, but these calls reminded me of the fragility of our working alliance.

This altered self-state in which his ego boundaries had partially dissolved, a state not healed by medication, has presented a major impediment to psychotherapy. What Sean most needs to talk about, his guilt, he cannot talk about, for fear of causing greater offense. Nevertheless, every 2 to 3 weeks an opportunity presented itself to do some "guilt work." For example, in one session he was very disappointed that even though he thought he had had "a good week," the Monday horns did not speak in his favor. He was uncertain what thought-crime he had committed. He allowed me to express sympathy for him, which would not always have been the case, concerned as he was about not offending the CoF. I spoke of his disappointment with them. "It is very unfair. You try so hard to please them." He said, "Yes, I do. I try to please them every day." I added, "It is especially unfair when you get no indication from the CoF what it is that you have done to offend them."

An opportunity for "guilt work" occurred in a session in which he began weeping as he sat down in his chair. Overcome by his sorrow, he couldn't help but register a complaint against the CoF. In obvious despair, he said "I don't know what I have to do! I thought I had a good week! I was thinking they would let me off but they still didn't end it. I may have to get

somebody else involved." He mused that perhaps he could contact the Mayor of New York City to intervene in his behalf. Or maybe he could appeal to the national audience who was watching. Surely there must be someone among the million viewers who would take pity on him and come to his aid. Or maybe he should switch his book/movie deal to Netflix. I knew that his defiance of the CoF put him on shaky ground.

I work at a community hospital with an active emergency room. Ambulances come and go all day. My office is on the 5<sup>th</sup> floor of the hospital, not directly adjacent to the emergency room. I hear sirens in the distance from my office but have acclimated to the stimulus and don't find it particularly noticeable or disruptive. When an ambulance keeps its siren on all the way into the emergency room ambulance dock, the siren can be heard from my office. Well into his rant, Sean looked up anxiously and said, "Hear that!"

He drew my attention to an ambulance siren. I said yes, I hear that. He said the CoF had sent the ambulance to message him with its siren, akin to the horns in his neighborhood, that he had crossed a line of disrespect. I used this occasion to take out my CBTp toolbox.

I continued, "I hear the same ambulance you hear, but I don't hear the message you do. It's like the traffic horns in your neighborhood. You hear a message that no one else does." I continued, "As you know, this is a hospital. I often hear ambulances bringing patients to the hospital. I assume every ambulance that comes to the hospital isn't a message to you. Right?" He said of course not, but the CoF knew he was here.

Circling back to "drill down" on the activating event A as described above, I asked him, "Okay. So we have ordinary ambulances with as-usual sirens and then special sirens that are messages to you. How can you tell them apart? How is the sound different?" I had long ago considered scheduling a session with him on the street in his neighborhood on a Monday morning when I could be present with him when he heard the horns, but for a variety of reasons, had never done so. Unlike the horns, which I had never heard, Sean and I had just heard the same auditory stimulus. I wanted to capitalize on the opportunity. He said, "You know. You can just tell. It's the way it goes up and down." He was referring to the warbling cadence of the ambulance siren. I said, "I heard what you heard, the sound going up and down, but the message I took from the siren was, "An ambulance is coming. Stay clear of the road. To me, it sounded like an ordinary ambulance siren. But it was special to you. Are you interested to know what I think the difference is?" He said yes.

I said,

Sean, remember that video we watched together that shows how we hear what we expect to hear? When you think something that might be critical of the CoF, or when, like today, you talk about getting someone else involved, you expect the CoF to send you an order to stop. That's what just happened. You felt worried that they were listening today, as you think they always do, and that you had offended them. You expected to get a message from them, and then you heard what you expected to hear in the sound of an ordinary ambulance siren.

Outside the familiar territory of his neighborhood, he felt on uncertain ground. He

allowed our discussion to continue. Aside from repeating that he knew the siren was a message to him, he could not articulate what about the siren gave him this impression. In the end, he conceded the point. "Maybe this one time it wasn't a message. But the horns are a message." Like mountaineers facing a long climb, I thought we had placed a piton that might serve as a future support.

Like psychodynamic therapists, CBTp therapists regard the therapeutic alliance as central to treatment. But CBTp places logic more in the forefront of technique than does psychodynamic psychotherapy, which explores symbolic meanings, which, because they are figurative rather than literal, are not inherently logical. Because of CBTp's relative reliance on logic to examine evidence and generate alternative explanations, a patient's refusal to embrace the implications of logic poses a particular resistance to CBTp technique. Resistances to the use of logic can be described and categorized (Garrett et al., 2019). Sean's concession that hearing a message in the siren may have been a mistake, while holding to his belief about the horns in general, is an example of "logic partitioning" in which a patient concedes that logic suggests that one particular belief is likely untrue, without applying logic to other apposite delusional beliefs or recognizing the psychological processes that repeatedly generate false ideas. Psychodynamic therapists are used to pointing out psychological resistances to patients. CBTp practitioners, less so. Most psychotic patients employ a number of resistances to the use of logic in psychotherapy which must be addressed in CBTp if to progress.

### ***Sean's Fear That His Free-Associative Mind Would Betray Him to the CoF***

In one series of sessions I sought to define and rehearse with Sean the two reasons I thought he felt more guilty than most people. First, I commented on his offering no objection to the CoF's holding him responsible not just for his actions, but his thoughts as well. I reminded him that people can to a considerable degree control their actions, but none of us can control our thoughts. Thoughts come to us unbidden as though they are posted on a mental screen where we apprehend them. He agreed that he couldn't control his thoughts and accepted that other people couldn't control their thoughts, either, "But they want me to, so I try to control my thoughts."

I told him I understood that he was reluctant to rile the CoF in any way, as he might by pointing out the impossibly high standard they set by requiring him to control his thoughts, but that I could say, if he could not object to their impossible criteria himself, that this was extremely unfair. The CoF standard was so high that no one could comply. No wonder he kept falling short. He nodded his head, clearly appreciating the sympathy. Next, I said, "As if that weren't bad enough. Not only do you feel guilty about your thoughts, but you believe every thought the CoF doesn't like is broadcast to a million people. While most people can think a thought in the privacy of their own mind, and no one knows about it, you end up being shamed in public." He understood and agreed. In an effort to help him rehearse this appraisal of the unjust impossibility of his situation, I wrote these two reasons he felt extra guilty out on a 3x5 index card and suggested a homework assignment in which he might review these reasons during the week and write them out in his own words. He said okay to that.

In the next session I asked if he remembered that in our last session, we had talked about two reasons he feels more guilty than most. He said yes, he remembered that we had talked about

reasons he felt guilty, but he couldn't remember the specifics. I slowly rehearsed the 3x5 card with him, asking him to paraphrase as we went along. He struggled to make the concepts his own, which puzzled me. His memory for some things was impeccable; e.g., he might ask me at the beginning of a session whether I had gotten more coffee stirring sticks, since I had run out the previous week. His comedic timing was quite good. He could readily recall a remark I made early in a session and, with appropriate tact and timing, revive his memory of what I had said to tease me. His innate intelligence is average or better. No formal thought disorder was apparent when he did express himself. He denied hearing voices. Yet he struggled to take in the two reasons. I asked him if he found it hard to concentrate on what I was saying for any length of time. He said yes, and then he led me to understand something about him that I had failed to grasp in previous sessions.

He described how he had to be constantly on guard against having a disrespectful thought about the CoF. To this end, he made a constant effort to fill his mind up with thoughts that would preclude thought-crimes. He spent a good deal of time daydreaming about dating "Megan." At other times, he played word games in his head, repeating syllables over and over, as if in an effort to jam a radio broadcast with static. As we all know, if someone were to tell us, "Under no circumstances think about pink elephants!" the first thought that would come to mind, if not immediately then in short order, would be about pink elephants. He lived in fear that his free-associative mind would betray him to the CoF. He was trying to suppress his thoughts by constantly distracting himself, which impaired his ability to think, and once a thought he imagined might be disrespectful emerged, as such thoughts inevitably did, he believed he could not cloak them in the veil of subjective privacy we all assume. The machine could read his mind, and the members of the CoF were listening. The so-called negative symptoms of schizophrenia including thought blocking are generally attributed to organic deficits in working memory and other cognitive mechanisms. In Sean's case he was intentionally trying to maintain two parallel tracks of awareness, one in which he tried to pay attention to people talking to him, and the other where he voluntarily tried to block his own thoughts.

### *Sean's Talking About His Father and Uncle Ronan*

Despite this severe constriction in his free-associative process, over time, some information slipped past his suppressive efforts, shedding some light on his delusion. Several months into the treatment, I asked him about his relationship with his father. He said it was "good," more like contemporaries ("drinking buddies") than a hierarchical father-son relationship. I asked if he was afraid of his father. He said no, but added that he was afraid of Uncle Ronan, who lived across the street from him when he was growing up. His mother was in the habit of calling Uncle Ronan over to dispense discipline, namely corporal punishment, when he misbehaved. When I expressed sympathy with his situation of being struck by his uncle, he dismissed it as, "No big deal. That's what they did in those days." He then said, although he clearly thought it was somewhat odd, that even though Uncle Ronan was in a nursing home, he still felt afraid of him. My effort to elicit more of his feelings about his uncle was met with an impatient, "I already told you about that, Doc. Let's move on." My best guess would be that Uncle Ronan was ancestor to the CoF, and the dread he would feel about his arrival, which is the worst part of that kind of "Wait until so-and-so gets here!" threat, is mirrored in his dread of the

messages he will get on Mondays.

Although the delusion of the CoF was sufficient for me to infer a severe Oedipal conflict, further confirmation came in a session when we were discussing baseball. He recalled an interview with a baseball Hall-of-Famer who remarked in passing that his father had been very strict and Sean said, "My father would have killed me if I ever disobeyed him!" In a different session, not proximate in time to the baseball discussion, Sean mentioned that an older man (Patrick), a few years younger than his father, had recently died. He said he missed him. He warmly recalled having "fun" times with Patrick when he was growing up. Similar to his relationship with his father, this older man had been a "buddy." Sean did not speak of his father as someone who guided him and prepared him for life, but more like they were comrades in the same generation. Recalling Sean's occasional remark about the CoF ("They are good guys once you get to know them") and his consummate wish to have a close business partnership with the CoF when they ended their surveillance and moved on to the book/movie deal, I heard echoes of his nostalgic longing for a close male buddy relationship that he had had with his father and Patrick. Many times in his report of his week, Sean commented to the effect, "I had it! I was in good with Mr. A. But then I blew it!", implying that he was almost in possession of the close relationship he desired, but then, through his own fault, he squandered his chance. There was much grief and self-hatred in this self-accusation. I hope that in the long haul of the therapy process, he will internalize me as a caring Oedipal father who is trying to provide him some guidance, whose standards aren't so punitive as those of the CoF. I expect that if he comes to see me in this way, his need for the CoF has a good chance of declining.

### *Exploring Sean's Associations to Thoughts and Events*

Because of Sean's intent to voluntarily constrict his free-associative process, it was difficult to explore his associations to thoughts and events. Nevertheless, information occasionally entered into sessions unexpectedly. For example, in one such session he mentioned that he "saw the CoF in their room." He had never mentioned a room before. He was able to tell me a bit more. The "room" was the place where the CoF assembled to monitor him. On this day, Mr. B was in the room. I imagined the "room" as being like Lewin's dream screen (Lewin, 1946):

The dream screen, as I define it, is the surface on to which a dream appears to be projected. It is the blank background, present in the dream though not necessarily seen, and the visually perceived action in ordinary manifest dream contents takes place on it or before it. Theoretically it may be part of the latent or the manifest content, but this distinction is academic. The dream screen is not often noted or mentioned by the analytic patient, and in the practical business of dream interpretation, the analyst is not concerned with it.

Sean hesitated. "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.

### *Sexual Fantasy Life With Megan Fox*

Despite his being under constant scrutiny by the CoF, with his thoughts open to national view, he was able to maintain a sexual fantasy life, the central object of which was Megan Fox. He spoke of her with lust, but also with tenderness. For example, he remarked more than once that "She has a nice caboose."

At other times, he spoke of her as the hometown girl next door. In these instances, he was apt to repeat, "Meg. She's a good girl." At these times, he spoke with the tone of an earnest Jimmy Stewart in a 1950s movie, asking an attractive woman whose blouse was pulled tight across her breasts, drawn thin at her waist, "Honey. Are we having chicken for dinner?" Wholesomeness all around. His fantasy relationship with "Meg" had its ups and downs. Some weeks he would say with pleasant anticipation that she was going to be in New York, and he expected to "get together" with her. The following week he might report, "She found out that I wasn't necessarily thinking of a long-term relationship, so she called it off."

His thoughts and actions being open to public view inhibited his ability to masturbate in his apartment. From time to time, he arranged what he called a "rub and tug" at a local massage parlor, a phrase not part of my vocabulary in my youth, but whose meaning was clear enough. He knew where to go to find a female masseuse who would masturbate him as part of services provided. I imagined that he imagined that the ruse of the massage offered sufficient disguise to throw his observers off the track long enough for him to enjoy himself occasionally.

### *Hope*

Now nearing the end of this case study, I want to speak about *hope*. Melanie Klein elucidated the central role of persecutory objects in psychotic and non-psychotic persons (Klein, 1935, 1946). Typical persecutors in psychosis include the CIA, the FBI, the Mafia, the Devil, neighbors, ancestors, and nebulous organizations. It is not difficult to appreciate that persecutory delusions contain the patient's apprehension of injury. It is more difficult to see the yin and the yang dualism of the delusion. When a man attributes his suffering to a persecutory object, an underlying fantasy accompanies the paranoid delusion; namely, that once the persecutor is dealt with, a pristine self that has remained intact despite the persecution will emerge happy and triumphant.

In Sean's case, the CoF is the persecutory object. Once the persecutor has been dealt with, in his case by his meeting their demands, he will emerge into his pristinely preserved future with a book/movie deal and the love of Megan Fox. Sean's torment and hope are inextricably bound together in the CoF delusion. Eight years into his psychosis he keeps his hope alive by dividing his life into week-long segments. He avails himself of the capacity most people have to keep their hopes up for a week. At the end of most sessions, he would say with resolve, "I think it is going to be this week. This week, they are going to let me off." 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.

From time to time, I tried to introduce a variety of ideas to test Sean's commitment to the delusion. I once suggested that while he is waiting for the book deal, why not work toward something else at the same time? If he were to pursue other work, what would it be? Typically, he would answer landscaping, imagining he would work with his brother. When asked why not start that now, typically he would say "No need to, because the book/movie deal will be coming through soon, probably next week."

I coupled this idea of his doing something in the meantime with a metaphor. I said, "You are expecting to one day walk out the front door of your house into a new life of fame and fortune. I can't offer you that. I can show you a side door, a psychological door, where you stand a chance of recovering the privacy of your mind that you felt when you were young." I asked him which he would prefer, the book deal and Megan or hard work in therapy to recover his privacy of mind. He laughed, and of course said the book deal and Megan, but he added the proviso, "It depends on how long I have to wait. It would be great if it was like it used to be. When I was private."

I countered with a question, "What is the longest you would wait for a bus to come?" He said, "About 20 minutes." I said, "You have been waiting for the CoF bus for eight years. How much longer will you wait before setting out on your own?"

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.

### *Illustrative Transcripts*

In summary, in this case study I have described a man, Sean, imprisoned by an altered state of consciousness in which he has lost the subjective sense of privacy we ordinarily assume attends our thoughts and feelings. I have tried to paint a psychological portrait of one psychotic man. I have described the constraints this altered self-state imposes on psychotherapy, and what I have tried to do about this state of affairs, so far with modest success. I invite others to take up the challenge of tailoring a psychotherapeutic approach to this devilishly convoluted form of suffering. Who can see another way? What else can we do? How might one get around the particular challenges psychotherapy with psychotic persons poses? The following three transcripts are typical of sessions in which I have tried to interest Sean in an alternative to the book/movie deal. These three sessions (though not continuous) occurred in the most recent 6 months of his 18 month treatment.

These three sessions did not occur in successive weeks, but over time in the last 6 months of treatment. I write down short notes during sessions, and detailed notes after sessions, which in the 3 sessions at issue I have expanded to simulate a transcript. The simulated transcripts are not verbatim but accurately present the flow of sessions.

In Session 1 Sean and I reflect on the messages he hears in automobile horns and bird chirps. In Session 2 we discuss his pervasive feeling of guilt and his reluctance to give up his dream of having a movie/book deal and Megan Fox. In Session 3 he describes the inner mental space in which he sees "Meg" and the Council.

Psychodynamic therapists will observe that I am much more active in these transcripts than would be the case in a long-term exploratory psychodynamic psychotherapy, and certainly much more than in a psychoanalysis. Clinicians who believe that I am too active with Sean may have had positive experiences with withdrawn patients while themselves showing more restraint. In my time I have waited for near silent patients to speak, though never allowing more than five minutes of uninterrupted silence. I once waited nearly 3 months in protracted periods of silence before a man who believed I was a robot uttered a complete sentence. In my opinion, although others may argue for a different approach, psychotic people who already struggle to maintain realistic mental representations of other people should not be encouraged to regress by a therapist who presents as a "blank slate." Rather, therapists can convey in a warm tone in words and in an informal, spontaneous, conversational manner something of who they are as real people. This fosters a therapeutic alliance.

I make no claim that my way of working with Sean would be a good fit for other psychotic patients. Maybe some, but certainly not all. Sean is a man of few words. Early in treatment I left ample room for him to direct sessions, but he rarely rose to the invitation. Typically, he will start a session by saying, "Let's do some guilt work!" making it abundantly clear that he expects me to do most of the talking while he follows along. Given his speech latencies and his constantly being distracted to "jam" his consciousness with pleasant thoughts so as to not offend the CoF, it fell to me to provide a sense of direction. In effect, with Sean, the usual session rhythm, where the patient talks while the therapist listens, and then the therapist occasionally says something is reversed. For the most part, I talk and Sean listens, and then he comments occasionally.

If I were to claim to have invented a new kind of therapy for use with Sean (a claim I most certainly do not make), I might call it *osmotic absorption therapy*. I have evolved an active manner of working with him in which I state some of the same ideas over and over again, weaving them together with things we have spoken about in past sessions. In my experience with him if I present the same idea again and again, if not the first time around, then the second or the third I may capture his attention sufficiently for him to absorb something I have said. He does clearly remember some of what occurred in previous sessions. This is not the cadence of work with non-psychotic patients.

In our 18 months working together, he has become more consistently attentive in his listening and less strident in his dismissals of what I say. Like a person caught in a flood who can occasionally grab hold of a branch extending from a mid-river island, he can occasionally

grab the hand I repeatedly extend to him. He has sufficient insight that we can easily re-build our agenda of ideas (the guilt work) when it has been eroded in the previous week. Some readers may wonder if the comments he makes from time to time that seem to indicate progress in therapy are simply him compliantly surrendering to my sustained high level of activity. I can assure the reader that Sean is not a compliant man. He is at times abrupt and condescending toward his mother in the clinic waiting room, and at times, when I have said something that he thinks might get him in trouble with the CoF, he doesn't hesitate to tell me to cease and desist. In a threatening, angry tone, "Didn't I tell you to not go into that. Enough. No more of that!" Also, as anyone might who is reflecting on something a therapist has said, he agrees with some things, disagrees with others, and corrects me at times.

I have interspersed occasional comments in the transcripts, indented in a smaller font in case the reader wishes to look at just the transcript, to "listen" to the clinical material as it emerged without the distraction of commentary.

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**SESSION 1**
**T:** therapist

**P:** patient (Sean)

**T:** How is your week?

**P:** Okay..... but. the horns are still going.

**T:** So, the horns are still going. You and I have the challenge we have talked about before where it's limited what we can talk about because you're worried about offending the CoF and you want to remain friends with them so that in the end this all ends well. You want to be friends and partners in the movie and the book deal and then you hope your life will move forward. I realize that it is very difficult to raise questions about your interpretation of the meaning of the horns. There's a lot at stake. At this point, all your hopes for your future are on the Council allowing this book deal to happen. That's the prize at the end of the rainbow. You've been waiting for this for a long time.

**P:** Next week is eight years.

**T:** A long time. When all your hopes are invested in things going that way, it's not easy to think in a different way about the horns or the birds. I try to push ahead with thinking about this, because that's my job, but I want to be sensitive to what you think is too much, going too far. Since the horns are the main way that you know that they haven't let you off yet, can we talk some more about the horns?

**P:** Okay. I'll let you know if you go too far.

**T:** First, let me say something not about you and not about the horns but about the brain and about psychiatric conditions like the one you have, things I think are relevant to you. It's very common in bipolar conditions for people to interpret events and signs from the environment in a special way. And you know what one of the most common signs is for most people with psychiatric problems? It's not horns ...

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*[I refer to his illness as "bipolar" not because I believe that particular diagnosis applies to him. Schizo-affective or schizophrenia might be more apt. Bipolar is the diagnosis he accepts, even though he doesn't think his psychiatric diagnosis has anything to do with the CoF.]*

**P:** Steps!

*[Sean was making a well-timed, well-crafted joke. In our session the previous week I had mentioned another patient who read special messages into the footfall of the neighbors who lived above her. His joke demonstrated his ability to remember what we had discussed a week ago and to generalize the concept that we were talking about to his current situation.]*

**T:** Yes, steps. (We both laugh) Good. I'm glad you remember what we talked about last week. The most common thing that people think is a sign is a stranger looking at them.

**P:** What?

**T:** Someone looking at them. I'm working with a man [let's call him "Patient Z"<sup>1</sup>] who walks around Brooklyn who thinks that when someone looks at him, they are sending him a special message. People look at each other all the time on the street, but he thinks there is a special message to him that they know about his psychiatric history. He hears people whisper under their breath "He's crazy" and "He's bugged."

**P:** Hummm.

**T:** He [Patient Z] hears people whisper these things. We did an experiment that we can't do with the horns. He carried a tape recorder with him as he walked around to see if he could record people saying "he's bugged" or "he's crazy," and there was nothing on the tape. He was not actually hearing these messages coming from outside. These messages were coming from his mind in the way he was interpreting a person looking at him in an ordinary way. He would see someone looking at him he would interpret their look as being critical and then he would actually hear what he thinks the other person was thinking. Sean, you read a special message into the horns, which other people hear as just random traffic noise.

*[Some patients are able to take a realistic perspective toward people other than themselves. In effect, I am trying to enlist Sean to do CBTp on other people like Patient Z with the aim of his insight about others ultimately being available to his assessment of himself.]*

**P:** If there whispering, how is he [Patient Z] going to hear it?

*[By talking about other people with ideas of reference, I wanted to indicate to Sean that his situation is not unique and to invite him to practice CBTp technique vicariously with regard to another person like Patient Z, Sean is able to adopt a CBTp orientation to raise reality-grounded questions about Patient Z interpreting glances and hearing what he expected to hear, but Sean struggles to adopt the same perspective about himself. Using other people like Patient Z as*

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<sup>1</sup> I have added the name "Patient Z" to help the reader distinguish between Patient Z's beliefs and Sean's beliefs and reactions.

*examples to analyze can also dispel the feeling that most psychotic people have that their experience is unique and therefore beyond the understanding of anyone but themselves.]*

**T:** What you say is exactly right! It doesn't make sense that he would hear people whispering if he were walking around. How could you hear someone across the street if they were whispering?

**P:** Whispering especially

**T:** Right. That's right. You sound like me now, pointing out how some things don't make sense! (We both laugh) It doesn't make sense that someone looking at him [Patient Z] would send a message. Or, that he could hear a whisper across the street. And there's a lot about your story, Sean, that doesn't make sense either. We talked about that before, but let's stay with the whispering a little bit longer. He's interpreting the look of other people as a sign that they have secret knowledge of him and that they are mocking him in public. He comes to his session sometimes with his nephew. His nephew might say, "Sure. When we were crossing the street, I saw that guy looking at you. But everybody looks at everybody in Brooklyn. What's the big deal? People look around all the time, so to his nephew the look of a stranger wasn't a message at all. But to this man [Patient Z], a random look had a very specific critical meaning. The woman [who is also a patient of mine whom I had also mentioned] who heard the footsteps upstairs at another time in her life when she saw people look at her, she thought they were noticing her because she had a bad smell.

**P:** (Sean chuckles) Why? Doesn't she shower?

*[He is using a mature defense of humor to deflect the conversation away from any relevance to him.]*

**T:** No. She's very meticulous about her grooming. Which is why it didn't make any sense to her. She thought she was such a bad person that other people would think she had a bad smell. Just the ordinary glance of a stranger on the bus sent her the message that she was a bad person. We have a name for this condition. We call it "ideas of reference." Shall I repeat that? Ideas of reference.

**P:** What? Ideas of reference?

**T:** Yes. It means a person has an idea that something is happening in the outside world that has a reference to them. Just like when you hear the horns on Monday you think the horns are making a reference to you. That they are sending you a message.

**P:** Why did they think the guy was bugged? Did he do illegal things?

**T:** No. He's a psychiatric patient but is not a criminal.

**P:** He is a scumbag if he was going around with a bug.

**T:** Oh, you mean like if he was wearing a wire, like a recording device to get evidence on someone.

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**P:** Yeah

*[In keeping with his psychology, he interpreted the "he's bugged" to mean "he's wired" as though people on the street were calling the man a snitch.]*

**T:** No, they meant bugged as in "crazy." Bugged out.

**P:** Oh, I get it. I'm glad we cleared that up.

**T:** I know how important loyalty is to you. You are not a snitch. And you don't want to snitch on the CoF by complaining about them.

**P:** I would never do that!

**T:** I know you wouldn't. He [Patient Z] thinks everyone on the street knows his psychiatric history but actually it is private. Not like you, he doesn't think that people can read his mind, but like you, he feels he has lost his privacy. He thinks that everyone is judging him at a distance. It's worse for you because you don't feel like your life is private and you don't think your mind is private. But he's [Patient Z's] made progress in psychotherapy. Last week he told me that if people are looking him it doesn't necessarily mean that they know about his psychiatric history. He asked how would anybody know by looking at his face that he had a psychiatric history? That didn't make sense to him, though it seemed it was happening that way. He asked a good question. No one would know. I told him you are right. You [Patient Z] think that a million people know about you.

**P:** They do! (he chuckles)

**T:** That's what you [Sean] say. That's what he [Patient Z] used to say. He used to say everybody in Brooklyn knew about him because he could see it in their eyes that they knew.

**P:** Not everybody in Brooklyn.

*[He said this with a slightly droll way, as if to say, "Come on! Everybody!?! You have got to be kidding. If he is walking around in his neighborhood, how could everyone in Brooklyn see him?" When at times in the therapy I have exaggerated a point to emphasize it, as one might when saying "you always" or "you never" without actually meaning always or never, he would catch me, as if to say that my exaggeration of a point invalidates the idea I was trying to put across. These constitute non-psychotic defenses that protect the delusional belief from scrutiny (Marcus, 2017)].*

**T:** But for you [Sean] it isn't just Brooklyn. You think a machine that doesn't exist sends your thoughts to a million people who are watching you like in a reality TV show. I know that you think we are being observed right now in our session. It feels to you that your thoughts aren't private. You understand that the way this other man is looking at things is a bit off because you are raising good questions about what he is thinking. You are pointing out where his story

doesn't make sense. How could everyone who looks at him know that he has a psychiatric history? They can't. It's just that he is self-conscious about being a psychiatric patient, and that makes him think that everyone knows. You hear special messages, and it's always the same message from the horns telling you that you don't measure up. That you aren't good enough. You hear a horn and there's a meaning in it for you that no one else hears. Same deal. I know that because it actually happened in the office here once, when you thought an ordinary ambulance siren was a special message to you.

**P:** Yeah. That happened once. Maybe I was right that one time.

*[This is an example of a defense against the use of logic in psychotherapy—"logic partitioning" (Garrett et al., 2019)]*

**T:** Okay. Yeah. But how many examples do we need to show how your mind works? We really only need one.

**P:** That's not true. Not every car is sending me messages.

**T:** Okay. Just a lot of them for 8 years.

**P:** A couple, I guess.

**T:** Well yes, week after week for 8 years, the message is the same. I should be careful with you not to say "all" or "every" because that just gives you an easy way to not think about what I'm saying. You think what I am saying is too extreme, exaggerated. The bottom line is you regularly hear messages in the traffic noise in your neighborhood that no one else hears. It's always the same message that they aren't letting you out. Other people just hear random traffic noise. The message isn't in the way the horns sound but in what you think the horns mean. The horns don't say, "We are observing you for another week." The horns don't actually say those words.

**P:** No, they don't . . . . But I'll find out Monday morning if the birds are chirping.

**T:** If I remember correctly, the birds, like the horns, they are a message the CoF are not letting you out. If there is no chirping, you are getting out. Do I have that right?

**P:** Yes.

**T:** There are birds all over Brooklyn and New York City and New Jersey, where I live. They chirp all the time. That's how birds communicate with each other. They are not communicating with humans. Where other people just hear ordinary bird chirping, you hear a special message to you. Hearing a meaning is common in psychological conditions like you have. The man on the street in Brooklyn heard special messages that no one else heard. The woman heard messages in footsteps upstairs. You hear messages in horns and bird chirping. So, let me ask you a question about the birds. You think if I went to your neighborhood, and we heard birds chirping, that you would be able to show me what regular, ordinary bird chirping sounded like and how the birds that were sending messages to you sounded different?

**P:** I don't know. But I just know.

**T:** Stay with me. But you hear birds chirping from time to time, yes?

**P:** Yes.

**T:** Yes. Everybody does. Are you saying that every single time a bird chirps it's a message to you?

**P:** No! (as if to say, "What a ridiculous question!")

**T:** (In a jocular tone) Back to my question, how do you tell the difference between an ordinary chirp and the special chirp? Explain it to me?

**P:** I don't know. I just know.

*[Using the CBTp technique of "drilling down" on the A, some patients can be led to understand that their delusion is based on their personal feeling about something rather than demonstrable facts that can be shown to other people. This marks the delusion as a mental phenomenon rather than a perceptual reality.]*

**T:** So, you just know they are different. It feels to you like they are different but you can't say exactly how, because they sound the same. The difference in the chirps is how you feel about the sound, in your mind. The chirp is different to you because of the meaning that you read into the sound. It's you that makes the bird chirp special. There are lots of birds in your neighborhood chirping away. No one else is hearing special messages from the birds.

**P:** Sometimes it's one chirp. Sometimes it's a louder chirp.

**T:** That's the way all bird sounds are! Sometimes one chirp. Sometimes louder. Sometimes softer.

**P:** Sometimes they will go "shhhee-shheeee." They make different sounds.

*[Defensively, he is trying to come up with some difference in sound that distinguishes the meaningful chirps from the ordinary.]*

**T:** All birds do. I think you are feeling frustrated right now because you can't explain how a message chirp is different than an ordinary chirp.

**P:** No! Wrong, wrong, wrong! (exasperated)

**T:** Remember the man who was reacting to people looking at him. The looks were all the same but he was reading special meaning into the looks of strangers.

**P:** Yeah, but he was a little nuts!

**T:** But aren't you a little nuts too? There is so much in your story that doesn't make sense. A machine that doesn't exist. A million viewers watch you suffer but no one offers to help. They



just enjoy watching you be tortured. The CoF doesn't let you off even when you have a good week. Eight years of punishment when you are a good man who has done nothing wrong. Punishment for your thoughts when no one can control their thoughts. Messages that no one else hears. Sounds a bit crazy, doesn't it?

**P:** (Sean smiles, then says) I am not nuts. This is real.

**T:** I say that your story is a little bit nuts because it doesn't add up. It doesn't make sense. Even you say it's crazy. You are like the man on the street and the woman who heard footsteps, reading special messages into the sound of horns and bird chirps that nobody else understands. You are so invested in the CoF that I worry that you won't want to change your mind about them. You have bet your whole future on the Council. I worry that I may stir up trouble for you by raising questions about your beliefs. But I can't help but do that because it's been eight years. If you don't think about your situation, you may have another year and it will be nine years. And then 10 years, and before you know it, your adult life will have slipped away. You still have a chance to go in a different direction if you decide to not wait anymore for the Council. You don't want to give up your ideas about the Council. You hold on to them even when there's something about your belief that doesn't make sense even to you. When other people have the same ideas as you, you say they are crazy and you are not. You're trying to not think about your beliefs. You put all your bets on one horse - the Council.

**P:** My situation is different because mine is real.

**T:** Sean, you just did it again, just now. You want it to be real because there's a prize for you at the end. That prize is very alluring. You're not very different than any of the people I've been telling you about today.

**P:** But I know it's real!

**T:** That's what they said, too. They all said exactly what you are saying. I'm not kidding. That's the way this condition works. It always feels completely real for everyone who has your condition. That's why it's so tricky. It's a powerful illusion. It seems so real. And yet it's an illusion. You put a meaning on ordinary horns and bird sounds. The man who was hearing people mumbling about him on the street didn't know the mumbling was in his mind. But it was very real and very convincing to him what was happening. But for that man there was no reward at the end. No book or movie deal. No Meg. He just wanted to get his privacy and his ordinary life back. He's lost time but he has started to question his beliefs about the meaning of someone looking at him. Okay. We are nearing the end of our time. Ready for your second espresso?

**P:** Yeah. Sure. Thanks.

## SESSION 2

**P:** These small machines, the espresso comes out hot. In the café it doesn't come out like this.

**T:** I guess in a café the bigger machines absorb some of the heat. There's no way I can turn it down.

**P:** That's okay. It's fine.

**T:** So what's doing with the horns this week? Do you remain optimistic about the deal coming through?

**P:** I need some guilt work. That's why I came in today.

[I originally coined the phrase "guilt loop" while Sean later coined the phrase "guilt work," which we came to regard as an overall rationale for our meeting that has a professional work orientation rather than a dependency, and more specifically refers to our aims in psychotherapy to talk about his feelings of guilt.]

**T:** Okay. Let's do some guilt work. Let's talk about two things that are directly related to each other. The first is you wake up every day of your life with the expectation of being judged by the Council. I would say that is a guilty atmosphere. Yes. If you didn't feel guilty at all or possibly guilty you wouldn't wake up worried that way.

**P:** What you mean I wouldn't worry?

**T:** You expect some kind of judgment every day.

**P:** Uh-huh.

**T:** It's built into your day. Most people do not feel like that when they wake up in the morning.

**P:** I didn't used to be like that either.

**T:** Yeah. Before, you would just go through your day. You would do whatever you were going to do, and every once in a while, you might feel guilty about something. But your whole day ....

**P:** I am hard on myself as it is.

**T:** You're very hard on yourself. That's the understatement of the century! (both laugh) You're constantly criticizing yourself. You're constantly judging yourself. And, when you experience the guilt inside your mind the right way, the old way, the healthy way, when you experience guilt inside your mind, it's about some particular thing that actually happened, and you know what that thing is that you are feeling guilty about. But the bipolar illness creates a situation where that guilt goes out of your mind and makes a whole atmosphere during the week where the Council – and I know you don't believe this – the Council are really an extension of your guilty mind. How do I know that? A lot of ways.

**P:** No. That's not true.

**T:** That's what you always say. And this is what I always say: One of the reasons I know that is that there is no machine that can read your mind. That's a basic part of your story. Machines like that don't exist but you needed to invent the machine to make your feeling that you had lost privacy in your mind make sense. You feel constantly like you're being observed, constantly like you're being judged. That atmosphere of always being judged is your guilty conscience, your voice of conscience. It's your superego as we say in psychology. It's you constantly thinking, "Am I doing the right thing? Am I going to give offense to the Council?" You are twisted up in knots about "Should I do it this way? Should I do it that way? Will that cause offense? If I do it that way, will they release me this week?" – and on and on and on. It's like you are in court on trial every day. That's the mind of a guilty man.

**P:** I think they're going to give it to me this week.

**T:** That's what you always say to keep your hopes up.

**P:** You're right.

**T:** Just to make the point, we can do a calculation. There are 52 weeks in the year. You told me before that you won't wait more than 20 minutes for a bus. There are 52 weeks in the year times eight years equals 416 times that you have said it's going to be over this week, but that never happens.

**P:** I know. I know. It's easy. 8 times 52. Whatever.

**T:** 416 times you said it will be over this week and you know how many it will be next week?

**P:** How many?

**T:** 417. I feel in a dilemma talking to you about these things because I don't want to diminish your hopes before you have an alternative. Something else that you could do, something else that you could focus your future on. You have all your hopes wrapped up with the Council. And if that turns out to be an illusion, which I think it is, what will you have to fall back on? And then we get into landscape work with your brother. But so far, you are determined to wait for the payoff. And as long as you are waiting for the payoff, you don't think seriously about working for your brother or doing anything else. So, you wait, and we wait together. 416 weeks you have been waiting.

**P:** 400 and what?

**T:** You've been waiting for a reward 416 weeks. Eight years. That's a fact that we can both agree on completely. There is no dispute about that.

**P:** What?

**T:** In 416 weeks of thinking it's going to be over it hasn't been over. So, we agree about that, right?

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**P:** Yeah.

*[This section illustrates how at times during sessions his attention appears to drift in and out, and at other times it is focused and he can remember what we have been discussing. I have come to believe that these lapses occur when he gets caught up daydreaming about Meg or some other mind-jamming distraction that is constantly running in parallel with his outward-directed attention.]*

**T:** 416 times you said this week is going to be the big week. But the evidence is that each week is just like the last. You keep your hopes up that the horns will go away, but they are still there because you still have a guilty mind. We haven't gotten to the bottom of why you feel so much more guilt than most people. If I'm right, my story makes complete sense. Because nothing is going to change until you change your mind about what you think is happening to you. You're feeling that you're being judged every day comes from your expectation that you're going to be judged every day, so you see signs in the horns that confirm your expectation. But that's not the way you see it. You think nothing is under your control. You just have to wait for the Council to give you the reward.

**P:** Yes. We are all going to make big money.

**T:** You'll forgive me. I'll believe it when I see it! (both laugh)

**P:** I don't blame you. It's a crazy thing.

**T:** It is crazy.

**P:** It's fucking crazy!

*[The CBTp oriented aspect of sessions has begun to amplify his own sense of puzzlement over his situation. His experience of his delusion being "crazy" invites alternative explanations.]*

**T:** You know why it sounds so crazy?

**P:** Why?

**T:** Because it really is crazy. It's the bipolar. It's the illness creating this illusion. That's why it doesn't make sense. 416 weeks you've been waiting for your reward. Even weeks that you've said to yourself you had a good week. "I'm comfortable. I'm in a good mood. I didn't do anything. I didn't offend anyone." But still the surveillance doesn't end. It makes no logical sense. What is the CoF waiting for? The feeling of surveillance is an illusion that the bipolar illness creates. A powerful illusion that leads you to hear guilty meanings in random traffic noise. Because your mind keeps doing that week after week, each week the horns and the birds seem to keep sending you messages. It's not because the Council is still operating the machine. It's because your mind is still creating the illusion. The surveillance continues week after week because your mind keeps creating the illusion week after week. You're trapped in that illusion. And you know why you have some peace in the middle of the night?

**P:** Why?

**T:** There's less traffic. There's less for you to misinterpret.

**P:** At least at night I know nobody is watching. Well, maybe a few people are watching.

**T:** I'm sure there's less traffic in the middle of the night, too. If there's no traffic, there is no message, no horn to misinterpret, so your mind can be quieter. During the day there are plenty of horns for you to misinterpret. We saw that before when you misinterpreted the ambulance siren as a special message to you. So that's why this surveillance doesn't end, Sean. It doesn't end because you're thinking about the horns, and the CoF doesn't change. I wonder if you want to change your thinking, because you're waiting for the movie and book deal payoff at the end? Changing your mind about what's behind these messages would be a totally different way to think about yourself and would be very difficult. I'm not sure that you want to do it. I'm not sure that you can do it. Because if you were to say – and I know you don't believe this – but if you were to say "I'm a good guy but I have this bipolar illness. It's not my fault. I'm a good guy. My illness has cost me my 20s and 30s but I'm not going let it cost me my 40s and 50s." You might be able to see that the bipolar illness creates an illusion in your mind where you hear random traffic noise as signs of guilt. A way to bring this to an end is to understand that this is an illusion that your mind is creating. And the reason it doesn't end is that your mind keeps creating it every Monday. This is what I showed you on the video on the computer, where that neuroscientist showed how you can hear random noise as a message if you expect to hear a message. Remember that video? That's you. That's what's happening to you.

**P:** No.

**T:** Most people just hear ordinary traffic noise. But because you are expecting a message, you hear the Morse Code. But nobody else hears it. It's a crazy story in many ways. It's crazy because there is no machine that can read someone's mind. Another way it's crazy – did you ever wonder why, if the Council is a group of four real men, why would they pick this particular way to communicate with you? Have you ever thought about that?

**P:** How else could they do it?

**T:** There lots of other ways. Send you an email. A text. Speak to you directly.

**P:** They're going to do it that way after this is over.

**T:** Why would they wait now? It doesn't make sense. Why would they pick this way, traffic noise instead of a cell phone? Everyone has a cell phone these days.

**P:** I have no idea.

**T:** You have no idea because it doesn't make sense. Who communicates these days through traffic noise? Can I make a joke?

**P:** Okay.

**T:** Instead of using a cell phone, maybe the Council will start communicating with you in smoke signals, the way the Indians use to do in cowboy movies. Who would pick traffic noise to communicate such a very important message? If they were communicating with you by text, there would be no opportunity to misinterpret. The words would be right there on the phone screen. Your mind couldn't make an illusion of a text, but it can make an illusion of traffic noise. If these councilmen were real people and they had a machine that could read your mind, they certainly would own a cell phone they could use to send you a text. You and I communicate by text. And if the Council were texting you, you would just show me their text. Simple. No confusion. But in the traffic noise you're getting messages that nobody else can see or hear except you.

**P:** That's why they don't send a text.

**T:** A minute ago you told me that you have no idea why they don't send a text, but now you have started to make up an idea that fits your story. But that doesn't quite make sense either, Sean. Because if they were sending you texts and you didn't want me to see them, you could just not show me. Their communication with you would still be clear and private.

**P:** Why wouldn't I show you a text?

**T:** Because you don't want to do anything that might offend the Council. You keep a lot to yourself and you could keep a text to yourself. And they could send you a text with their sophisticated technology that deletes automatically five seconds after you read it

**P:** Like those email messages that say, "This will blow up after you read it!" (he smiles)

**T:** Yes. Like that. So if they're so sophisticated that they can read your thoughts, they could do all kinds of cell phone communication, but instead they choose random traffic noise to communicate with you? The reason this feels crazy to you is because it is crazy. It's the illness that's constructed this world of guilt. And trapped you in it. You've been ill for many years now. I'm trying to give you a second chance, trying to show you a different way, the hard way, and the choice is really do you want to spend your 40s and 50s waiting for the Council, who I don't think are ever coming.

**P:** No.

**T:** Do you want to let go of the fantasy book and movie deal?

**P:** I don't want to let go of that.

**T:** But you have to choose. That's just the way it is.

**P:** It depends how long I have to wait! I think it might be this week.

**T:** You've been waiting for this bus not for 20 minutes but for eight years.

**P:** This week, I think it's going to happen. You don't think so?

**T:** (The therapist laughs) I am skeptical.

**P:** (Sean smiles) I don't blame you. It's crazy.

**T:** It is crazy. Who would believe a story like this? Unless you were the one who made up the story.

**P:** Two people have to be there to see what's going on.

**T:** If I thought it would make a difference, I would meet you on your corner and we could listen to the traffic noise together.

**P:** But they wouldn't do the beeps because they would know that you were there.

**T:** That's what I thought you would think. That experiment wouldn't work. I consider that ambulance that we heard together as one time when two people were there. Me and you. We were talking about you wanting to get the Mayor involved, and you were feeling guilty about that, worrying that you had offended the Council. You heard an ambulance. I heard an ambulance. But your interpretation of the ambulance was completely different than mine. Your interpretation was that the Council were monitoring your thoughts with the machine – a machine that doesn't exist, by the way – and you think they know that you were talking about getting the mayor involved, so they pushed back with a warning through the ambulance. Like they were saying, "Careful, Sean. You're being disrespectful. I didn't hear that." That day I just heard an ambulance coming to the hospital bringing patients the way they always do. Same sound, different meaning for you and me. But because you were feeling guilty right there about the Council, you were expecting feedback from them, and you got the message you expected to get when you misinterpreted the ambulance siren as a message to you.

**P:** We will see, I guess.

*[This was said within an air of resignation rather than a strident assertion that next week is going to be the week of his big payoff. The adamancy of his conviction had diminished over time.]*

**T:** Well, we've seen 416 weeks. Next, we we'll see week 417 and see what happens. When I try to imagine what your life feels like to you, I know that you suffer.

**P:** I suffer a lot.

**T:** I know. I know that you wouldn't be eager to give up the idea of getting the book deal and Meg. You wouldn't be eager to give that up because there's a lot of money and fame involved. It isn't likely that you would give that up for an ordinary job, like working for your brother. When you have to choose between Hollywood and Meg or working for your brother, you would want Hollywood every time. Except Hollywood is never coming. Hollywood hasn't come in 8 years. But you could try to work with your brother right now. You could try to make a mark in the world in some way without waiting for the gold at the end of the rainbow. Without waiting for the Council to hand you your reward and give you your future life. Over the years, you've come

to believe more in the Council than in yourself. I am hoping to help you believe in yourself again, to change your life by changing how you think about things.

**P:** It is a terrible situation.

**T:** Yes, it's terrible. You've lost your 20s and 30s. You don't want to lose your 40s. At some point it's going to go one way or the other. You'll either keep waiting, and you keep waiting into your 70s, and then you will have waited your whole life for something to happen, and then someday, like all of us, because we all have to die, you'll pass, like we all will, and you will have spent your life waiting for a prize that never came. What I'm trying to do is give you a different way of thinking about your situation. I'm trying to help you believe in yourself, in your ability to figure out what's been happening to you and then choose to go in a different direction. If you're willing to give up the promise of the movie and book deal, you could work on having an ordinary life, but not a grand life, not a rich life. The path I'm talking about doesn't lead to Megan Fox. You could have a girlfriend, a local woman from Brooklyn. You could have a sexual life again. You could understand that your mind isn't being read, even though it feels that way.

**P:** Megan is there. She is waiting for me.

**T:** I hope you can forgive me for saying this because I am trying to tell you the truth. Your reward hasn't arrived in 8 years. I don't think it's going to arrive. I'm trying to help you to find a bridge back to your old life, your old self, the person you were when you were younger, when you knew that your mind was private.

**P:** It was good then. It was good.

**T:** Your mind was private before the bipolar turned your mind inside out. You had money coming in. You are working. You had a sexual life. You were independent. You weren't afraid of your own thoughts. That was the old ordinary Sean. I'm trying to show you a road back to that old way of being. But there's no Megan Fox on that road. Just ordinary Sean who lives in Brooklyn, not Hollywood, who has lost time in his life but still has some left. The person I'm trying to help you get back to is the ordinary Sean you once were. So there you are. Which deal do you want? You say even though you have been waiting 416 weeks, you will wait another week. Because the prize is so wonderful. The book deal and Megan. "It's only a week," you say to yourself. "I can wait a week." If in this coming week the horns stop and you get approached for the book deal, okay. I would say okay, you were right after all. I was wrong. So enjoy your life. Enjoy your money. Enjoy Meg.

**P:** But I'm going to enjoy the round-trip first-class tickets first. (Sean, with a guffaw. He is referring to a promise that I had made some months earlier that if the book deal came through, I would celebrate with him by personally paying for first-class plane tickets to California so that he could see Meg. He had joked at the time, "I want two tickets. I want two round-trip, first-class, so Meg and I can go together. With humor, he was calling me on our previous wager.)



**T:** Yeah that's right. I will definitely fund that. But to tell the truth, I'm not that worried about having to pay up. 416 weeks. No prize. I think the odds are in my favor. I don't see evidence that the book deal is going to happen. The whole situation is crazy. But if you could change your mind, you could be like many people like you who have psychiatric conditions who have fought for your own recovery. That would be hard work. It would mean figuring out if you're going to start with your brother, what would you do? Would you start out part-time? What would you be paid? What skills would you need to do the work for your brother? There is no Megan Fox along that road. No big pot of money. Just the money you would earn yourself.

**P:** I was thinking about getting a job. I could do the landscaping with my brother..... But I'm waiting. I'm waiting for my friends. (By which he means the Council)

**T:** One of the things that is heartbreaking about your situation – tragic – is that I know that if you ever tried to think about doing something for yourself, you think it takes away your chances of getting a reward from the Council. You want them to be your friends. You want to be partners with them. So just the idea of doing something on your own goes against what you hope will happen in a friendship with them. Because there is no such thing as a machine that can read minds, and the Council communicating by traffic noise rather than cell phone, and because there is no change even when you have a good week, and because no one can control their thoughts, the whole story is crazy in many ways. The truth is you are a good guy. You've done nothing to deserve the treatment you received. You are a good guy who fell ill with bipolar. One of the things this illness did was rob you of a sense of your privacy in your mind. The brain constructs our feeling of privacy. With that feeling of privacy gone, you made up a story to explain how you were feeling. And then you got trapped in that story where you thought you had no power on your own. You can only wait for the reward from the Council. I think it would be great if you were to start working. Then you could test things out. See how it goes. But I understand that you don't want to give offense to the Council. You want to keep communicating the message that you're all in with them. You don't have any alternative plans.

**P:** Yeah, I know (chortles). Ain't that the truth.

**T:** I'm ready when you are. Are you ready for your next espresso?

**P:** We did good work today.

**T:** Yes, we did. You really earned your espresso today!

### **SESSION 3**

As mentioned in earlier in the paper, Sean once described seeing the CoF in a room akin to Lewin's dream screen. In his seminal paper, "On the Origin of the 'Influencing Machine' in Schizophrenia," Tausk (1933) describes a patient with a similar mental space. In this session, Sean placed Meg in this mental space. The CoF arrived later. The session began with coffee talk, as it often does, on this day with a discussion of the different proportions of milk and froth in a cappuccino, macchiato, and flat white.

**T:** If I'm remembering correctly, you said last week ... I wouldn't quite say you promised me but sort of like that ... you would try to tell me a little bit more about what goes on in your head. What goes on in your mind?

**P:** Well, Megan is on my mind.

**T:** How does it go? What is it like? Do you see her? Do you think about her?

**P:** I just make pictures. I have two pictures with her in it.

**T:** So, you bring the pictures up in your mind.

**P:** Yes ..... and the Council is in my head too.

**T:** There in your head in their part of the scene?

**P:** Yeah. In my brain. Whatever you want to call it.

**T:** I think you've mentioned this before. So, in the frame there's the Council, and Meg is in the frame.

**P:** Yeah.

**T:** I'm sure the pictures of her are nice to think about. What are the two scenes? Are you just looking at her or are you doing something with her?

**P:** We are holding hands in one scene. In the other one ... it's kind of weird. I'm fenced in. She's going like this (shaking her finger) and I put my hands behind my back and I'm lying on the bench. Then I turned that into her holding my hand.

**T:** So the one scene changes into the other one.

**P:** No. They're both there.

**T:** You're fenced in by an actual fence or you're just feeling stuck.

**P:** Stuck in a fence.

**T:** When she is shaking her finger, is that to admonish you?

**P:** Yes, to admonish me. To tell me to not to start grabbing her and shit.

**T:** Be polite.

**P:** Be a gentleman.

**T:** Be a gentleman, yes.

**P:** She's a doll.

**T:** I'm sure it gives you a lot of pleasure to think about, to imagine being with her. In this frame does the Council see her also, or just you?

**P:** I don't know. I'm not sure.

**T:** When you're looking at her ...

**P:** They can see the frame.

**T:** Do they ever get involved? Do they ever say anything? Or interact with her? Or you have a separate relationship with her?

**P:** Yeah, it's separate.

**T:** When you imagine her, do you see her clearly or is it kind of blurry?

**P:** Kind of blurry.

**T:** Like you're trying to remember her. Remember what she looks like.

**P:** Yeah. From her movies. I like all her movies.

**T:** I don't know her films very well, but she is certainly an attractive woman.

**P:** Yeah ... She's got a hot body. A smokin' hot body. She's got a great caboose.

**T:** And I know that to keep yourself in a more positive frame of mind, you repeat her name. It sounds almost like a mantra, like in meditation where you say her name over and over again.

**P:** Yeah.

**T:** It kind of fills your mind with ...

**P:** Good thoughts. Half of it is because I like her. And half because it helps me fill up with good things. Now it's more like 75% that I like her. And 25% just to fill in. But 75% of the time I'm thinking about her. I think about her a lot. Let's call it that.

**T:** That helps you get through your week. Thinking about her. When she appears in this frame on the screen, do you know that you are remembering her and imagining her, or does it seem like she's actually there?

**P:** No. I know that I put her there.

**T:** Okay, you know that you're making an image of her from your own mind to see her. You remind yourself of her and enjoy thinking about her. You know it comes from you. You know that you put her there.

**P:** Yeah.

**T:** It isn't the machine that puts her there. It's you.

**P:** That's right.

**T:** You're attracted to her. And you are thinking about her. Her smokin' hot body it sounds like in this frame, this mental frame where you see her and you know that you are imagining her. She isn't actually there. You're thinking about her. And the Council also appears somewhere in the frame. If I understand you correctly, you know that you're thinking about Meg, but it doesn't seem that when the Council appears that you are also thinking about them. You think that they are actually there. Like you're not imagining them, but that you are actually seeing where they are located. Do I have that right?

**P:** Repeat that.

**T:** You know that you're imagining Meg and enjoying it, but you don't think that you are imagining the Council. But they're all in the same mental frame.

**P:** Okay. Yes. As soon as I thought of them, they were there. They were just there.

**T:** So why is Meg different? You see her in the frame, but you know that she isn't actually there. Why don't you think you are imagining the Council?

**P:** Because I don't let her off..... She doesn't go off the page. I don't try to get her off the page. That's why.

**T:** I see. You keep her on the page.

**P:** I like her.

**T:** Yes. You keep her on the page because you like thinking about her.

**P:** I'm looking forward to dinner with her.

**T:** A reward for you?

**P:** No. It's not like that. It's just that we've been getting along. She's watching me. I'm watching her and thinking about her. And it will be a nice thing. (He seems to be describing a state of mind in which two lovers are always in each other's thoughts.)

**T:** So, let me draw something here. I don't know if the frame is square in your mind. .... So if this is a picture of the mental frame that you have where you see Meg, and you enjoy thinking about her but you know that you are imagining her. She isn't actually there in your brain.

**P:** No.

**T:** You're thinking of different images of her. Thinking about her movies. You're imagining Meg, so this is a mental frame. I'm putting in Mr. A, Mr. B, Mr. C, and Mr. D. They end up in the same frame sometimes.

**P:** All the time. No, not all the time.

**T:** I think you are just telling me that once you started thinking about them, they just appeared in the frame. What form do they take when they appear? You can see Meg in your imagination. You can remember clearly what she looks like. The Council members have a shape?

**P:** They are shaped like you so they look like a person.

**T:** They resemble a person. Shadowy?

**P:** I can't exactly remember.

**T:** So, no detailed faces.

**P:** No. No detailed faces.

**T:** Are there always four?

**P:** You mean in the scene? Sometimes there are four, but sometimes only one in the scene.

**T:** So, their faces are vague. You don't see their faces clearly. Meg you see more clearly. You certainly imagine her body clearly. I could see it on your face when you were describing her.

**P:** (smiles) Yeah. I saw a couple of her movies in the last month. That's how I remember her. But I haven't seen these guys in a long time. Well not ever, really. I've never met them all. I just remember, Mr. D I know.

**T:** Do you know what he looks like?

**P:** It's a little vague. Just a guy with his hair parted to the side.

**T:** No distinct facial features that you can remember?

**P:** No.

**T:** Now, here's some guilt work.

**P:** Yes! Please. Please! It's fucking horrible how they don't let me out.

**T:** It is horrible.

**P:** Fucking horrible. It's horrible, man.

**T:** I think the reason that you see Meg more clearly than you see the Council is because Meg really exists. You know what she looks like. You know what her body looks like. You know her movies. You have a lot of information about her. She's a real person who actually exists. So, when you think about her you have a clear picture of her. So why are the four Council so vague? You can't describe them really.

**P:** I haven't even met most of them.

**T:** You haven't met them because they don't exist. They exist in your mind. What's happening here is that when you think about Meg, you are imagining a real person. When you try to imagine a man that doesn't exist, that you've never met, you can't get very far with the picture. The Council aren't real people. The Council is the way you imagine your voice of conscience. It's your superego, like we say in psychology. And the superego doesn't really have a face. It's more a feeling of being observed and judged, which is what the Council does. You have given the Council outlines of bodies but without any detail because they aren't real people. They don't even have real names. Mr A, Mr B, Mr C, Mr D. What real man has a name like that? The Council is the way you imagine the part of your mind that judges you. We all judge ourselves with our voice of conscience, but the conscience isn't a flesh-and-blood person who is manipulating a machine. These are elements of your mind. It's the part of your mind where you are judging yourself, only it doesn't feel like that.

**P:** Yeah? So do I imagine them?

**T:** Yes. With Meg, you know what she looks like, because you've seen pictures of her. You can daydream about her. With the Council, these are four judgmental older men that you invented in your mind, but you only got through the first step. But you never fill them in with your imagination. You never filled in the picture with what they looked like. You never gave them real names. What I'm trying to show you, Sean, is this frame is a mental frame. It's a mental place. It isn't a real room where people are sitting around in front of a machine.

**P:** I never looked at the room like that. I never looked around inside it.

**T:** You know Meg isn't actually in your mind. You know that she isn't in a little room in your mind. You know that you're imagining her. The Council are in the same mental space as Meg. But you seem not to understand that you are imagining them as well.

**P:** Yeah.

**T:** It's your mind.

**P:** I know.

**T:** You know you are bringing Meg in with your imagination. The same thing happens with the Council.

**P:** They were all there before Meg got there.

**T:** Yeah. You brought her into your mind to help keep your spirits up while the Council treats you so unfairly.

**P:** We are going out on a date.

**T:** Without Meg, you are left alone with your guilty superego. We are doing guilt work here.

**P:** But the Council, that's the only way I can get out and be with Meg.

*[This raises the question of what the process of working through is in psychotherapy with psychotic patients. On the one hand, Sean understands that the Council is appearing in an imaginary space. On the other hand, he retains a conviction that he has to please the Council in order to extricate himself from their surveillance and get to a real person, Meg. Even when he sees the Council in a mental space, the space overlaps reality.]*

**T:** We know that you think that it's the Council has to let you out. This whole mental frame, this whole mental space, it's in your mind. It started with the Council in your mind, but it expanded. You brought in Meg to have something positive in your life. A little excitement. Meg is a real person, so you can image her clearly. She has a real name. The Council aren't real people, so you have no clear image of them. A guy who parts his hair on the side. That's it? That's barely a person. Sean, this is your superego. The Council is a stand-in for your voice of conscience. This is you in a disguised way. Remember, you once told me that the Council were in this frame and that there were women's breasts suspended above their shoulders. That is definitely your imagination! There is no such room, no such control space where women's breasts are floating in the air. That's just you, a healthy heterosexual man thinking about women's bodies.

**P:** I'm not thinking about Meg's breasts.

**T:** You were thinking about some woman's breasts that day, if not Megan's. Although why wouldn't you think about her breasts? You like thinking about her caboose.

**P:** Let's skip that. I don't want to go back to that. Okay! Just drop it.

**T:** But we have to talk about these things if you're going to get better. You can shout me down, and yeah, sometimes I go too far. I could fold my cards and just leave you alone. But I'm doing this to try to help you, because you been waiting for eight years for a bus that's never come. You lost your 20s and 30s. I think you're about to lose your 40s. As I don't think this bus is ever coming. It hasn't come in eight years. I'm trying to show you what's actually going on. And it's not what you think. It's an illness that is playing a terrible trick in your mind and it's twisting a good man, a man who's done nothing wrong, who doesn't deserve any of this, somebody who just wants to work and have a good friend and an ordinary life ...

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Pragmatic Case Studies in Psychotherapy, <http://pcsp.libraries.rutgers.edu>

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**P:** But having all that money would be great.

**T:** Sure. That would redeem your 20s and 30s. You could say I lost my 30s, but I got a get a big payoff. To believe me, you would have to say – and I'm not sure you're prepared to say this – that "The Council is in my mind," because if you change your mind to that belief, that's where the hard work starts. If there's no movie deal, what am I gonna do? How am I going to work? How am I going to recover my old life?

**P:** Stop early? (he is joking)

**T:** Oh, so you want to stop early today? (Both laugh) If the heat in here gets too much, tell me. This mental frame that you have, where you enjoy visualizing Meg and the Council, where there are these faceless figures that don't have any details that are not real people .... It's your guilt. These are images of your guilt. You feel guilty, for reasons that we don't clearly understand yet. You are a good guy. But instead of feeling your guilt is normal "inside guilt," the way you did when you put snow in your brother's face, you feel your guilt from the outside, as though your voice of conscience is outside you, as though your superego is outside you, judging you as the Council. That tells us that you created the Council to paint a picture of where it seemed that guilty feeling was coming from. You imagine your sense of guilt. It's an image that threatens you, criticizes you.

**P:** I never saw what Mr A and B and C and D looked like.

**T:** They don't have clear faces because you are trying to imagine someone you have never met, because they aren't real people. They watch you, the way my superego, my voice of conscience, watches me. But I know that my voice of conscience is part of me. The bipolar makes it seem like your conscience isn't part of you.

**P:** It's the opposite of the id?

**T:** That's right. It's the part of you that said, "Don't rub snow in your brother's face." That's the healthy superego. It's the healthy voice of conscience. It says, "Don't do that. You did wrong." That's the superego. We all have it. It's a psychological part of us. Instead of you feeling guilty in the old normal inside-guilt-feeling way, after your illness began, you started feeling your guilt in an outside way. And because it didn't feel part of you like your guilt used to, you created the Council in this mental space where Meg appears in your imagination. In normal guilt, most people hear the voice that sounds like a superego. People hear a voice saying, "Don't do that; you're wrong; you did a bad thing; don't do it that way."

**P:** That's your conscience.

**T:** Right. That's the way most people hear their conscience. You imagine your conscience is like a group of older men. It's the ancient law of the father. Younger men are afraid of older men. Most people with a healthy superego, they hear their superego talking to them. You don't. You imagine the existence of a machine and four men that exist only in your imagination that have replaced the normal mechanism of inside guilt. From a healthy form of guilt that you had



when you were younger, the bipolar has twisted your voice of conscience into the Council, where now, week after week, you try to please your superego in the form of the Council, even though it doesn't feel like it's a part of you. It feels like an outside tribunal of judges. Because they aren't real people, that explains why even when you have a good week and you have done everything you imagine they want, they still don't let you out, because they aren't real people. It leaves you feeling guilty week after week, without end. And half the time you say, "Wait a minute. What did I do wrong? I had a good week." You have a superego that is harsh and cruel that can never be pleased. I don't know where it came from. I don't know why you developed this intense sense of guilt. The only guess I have is that the Council are split up figures of Uncle Ronan. He was the law when you were growing up. He was the punisher. He was the law of the father. He was the law of older men. The person your mother would call to punish you. Your father wasn't critical of you. If anything, it sounds like you are friends and buddies. You go out and do stuff together. He wasn't judging you. But Uncle Ronan was. Uncle Ronan was the one who would punish you. And it's the Council that's punishing you now. I think the idea of the Council came not from your father but from Uncle Ronan. At one time, I know that you could take a beating and it wouldn't destroy you, so you kept going, but he was the enforcer. I think what happened in your mind was, it got all twisted up by the illness so that we don't see Uncle Ronan's face, but we see Mr. D, his vague face with the only detail his hair parted to the side.

**P:** All right, coffee time.

**T:** Okay. Thanks for listening. (both laugh)

### *Present Status of the Case*

At the time our weekly sessions had to be suspended because of the COVID crisis, Sean remained quite attached to the reward offered by the CoF, but he acknowledged, with a sigh and a shake of his head, that he had already lost most of his adult life waiting for a prize that had yet to come. During the COVID shutdown I remain in brief weekly phone contact with Sean, hoping to resume sessions when the crisis abates. I have offered him tele-medicine video sessions, to which he has replied, "We don't need that, Doc. Let's just talk on the phone."

## **7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION**

Structured instruments to assess progress have not been used in Sean's treatment because typically I have not found them helpful in the session-by-session work of psychotherapy with schizophrenic patients. I take the regularity and promptness of his attendance as an indicator that the treatment has had continuing value for him. I took detailed clinical notes immediately after each session, to document it, and in the three sessions presented in detail above, expanded these notes in a transcript format to simulate the conversational flow of a session.

In addition, I periodically consulted with colleagues about the case.

## 8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Although the therapy has yet to shake Sean's conviction in his core delusion, and although he has not been in treatment with me long enough to determine if psychotherapy will reduce the need for hospitalization, Sean clearly derives benefit from our work because he never misses sessions and is never late. I am the only person to whom he confides the truth of his daily life. I suspect that he will have to tire of waiting for the CoF to grant him fame and fortune before he can embrace a reality-oriented recovery. There are signs of this on the horizon. He has several times allowed himself to complain about the CoF in sessions, a prerequisite to parting ways with them. He verbalizes the idea of finding some form of work for himself, though he has yet to take any concrete steps in this direction. Although I do not expect that I can catch him before he falls (Bollas, 2012), I hope I might be able to catch him and lead him in a constructive direction were his despair over waiting for his life to begin to increase.

I wanted to write about Sean in part to bear witness to his great courage and his enormous resourcefulness as a survivor, despite the psychosis imposing severe constraints on his adult life. He has constructed delusional fortifications that hold the world at bay while he lives in a narrow enclave of mind in which he has managed to survive, maintain hope, and enjoy some pleasures, including eating, watching movies, occasional sexual outings, and being part of an accepting family. If he had a personal flower to emblazon his crest, it would be blue chicory, pushing up through asphalt rubble at the roadside, showing a determination to live, despite a spartan landscape.

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Table 1. Ten Forms of Psychological Resistance Encountered in CBTp  
(Garrett et al., 2019)

	<b>Name of Resistance</b>	<b>Brief Definition</b>
1	Logic evasion	Evading the implications of logic by claiming to be an exception to whom logic does not apply.
2	Logic monopolizing	Claiming to be a master logician who offers definitive logical proof of a delusion not open to any alternative line of logical reasoning.
3	Logic blinding	Acknowledging a logical conclusion while remaining blind to the emotional implications of a logical inference.
4	Logic partitioning	Conceding that logic suggests that some beliefs are likely untrue, without changing core delusions or recognizing the psychological processes that generate new delusional beliefs.
5	Equivocation	Offering vague, nonspecific, noncommittal responses.
6	Reactive reassertion	Expressing a reactive, strident reassertion of a delusion when the patient senses a conflict between the delusion and logic.
7	Feeling-percept fusion	Ignoring considerations of logic because of a strong "feeling" that the delusion is true, despite logical evidence to the contrary.
8	Mind-guarding	Resisting alteration of beliefs because change threatens to erode a vital psychological structure upon which the patient's identity, vitality, self-esteem, or emotional regulation depends.
9	Peripheral preoccupation	Preoccupation with an underlying emotional concern that is not embedded in a psychotic symptom per se and thus has not been recognized as a central focus of therapy.
10	External expectancy	Relying on external agents and contingencies as instruments of change rather than one's own hard work in therapy.

Figure 1. Three Elements of Psychotic Experience  
(Garrett, 2019)

