Journal of Contemporary Psychotherapy (2023) 53:235–243
https://doi.org/10.1007/s10879-022-09571-6

ORIGINAL PAPER

Navigating an Impasse in the Psychotherapy for Psychosis

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Accepted: 3 October 2022 / Published online: 17 October 2022
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Abstract
Despite pessimism in the field, persons experiencing psychosis can benefit from psychotherapy and recover. However, there are multiple factors that can interfere with the formation of a positive therapeutic alliance and lead to the premature termination of therapy, which is associated with poorer long-term outcomes. In this article, common therapist, patient, and intersubjective factors are identified that can inhibit personal growth and lead to stalled treatments. After reviewing these various roadblocks, four principles (e.g., an intersubjective orientation to realty, therapeutic openheartedness/vulnerability, "speaking the unspeakable", and recognizing the pain beyond the psychosis) are outlined that can embolden the therapist to take judicious risks while avoiding common pitfalls when working with persons experiencing psychosis. These principles also enable the therapist to maintain an empathic connection to the patient and appreciate the pain beyond the psychotic symptom. The clinical implications and challenges of embodying these principles and implementing these interventions are discussed.

Keywords Psychotherapy · Psychosis · Recovery · Impasse · Intersubjectivity

People experiencing psychosis benefit from psychotherapy (Lincoln & Pedersen, 2019) and meaningfully recover as evident by first-person accounts (Britz, 2017). However, therapists and patients face many challenges in their clinical work together. Disruptive symptoms such as paranoia and social challenges can complicate intersubjectivity and relatedness, essential elements of the psychotherapy encounter, as well as lead to withdrawal from therapy. Patients that avoid exploring meaning of their symptoms (i.e., a "sealing over" recovery style, see Ridenour et al., 2021) and who disagree with their therapist about the tasks of therapy are more likely to withdraw from treatment (Startup et al., 2006), Without a shared framework between therapist and patient, there remain roadblocks to the establishment of a therapeutic alliance. When these roadblocks result in premature termination of therapy, the patient faces a greater likelihood of symptom exacerbation, recurrent hospitalizations, and, in extreme cases, suicide (Kreyenbuhl et al., 2009).

Psychotherapeutic roadblocks, or impasses, are often the result of complex intersubjective processes that arise in the therapeutic dyad and can be intimately related to both the patient and therapist's core dilemmas and conflicts (Etchegoyen, 1991). Ferro (1993) suggests "micro-fractures of communication" and empathic misattunements can precipitate impasses. On other occasions, patients may withdraw into their psychosis to protect themselves and their therapists from frightening experiences of closeness, destructive feelings, painful truths, and challenging, unspeakable transference-countertransference dynamics (Rosenfeld, 1987). Indeed, this retreat can often occur following moments in

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therapy where the patient may feel known and understood by therapist, particularly in response to feelings of vulnerability or inadequacy (Leonhardt et al., 2018). Rosenfeld (1987) has argued that these types of impasses can resolve following a therapist's own self-reflection and countertransference investigation. In certain cases, therapy can reach an impasse in which neither therapist nor patient knows how to make headway. Various obstacles can emerge over the course of treatment, such as different perceptions of reality, disagreements about the focus of treatment (Startup et al., 2006), and intersubjective disconnection. When an impasse is reached, progress can slow to a standstill and stereotyped ways of engaging can emerge that prevent growth and development. Over time, this might lead to a shared sense of hopelessness and belief that nothing is happening in treatment. How do therapists navigate these tricky situations and find ways of staying engaged without falling into stale interventions?

In this paper, four factors will be analyzed that often drive a treatment into an impasse. Following this, four principles are offered for therapists that can embolden them to take risks to avoid these dead ends: (1) An intersubjective orientation to reality that honors both patient and therapist perspectives; (2) The ability to vulnerably engage with the patient and speak from the heart in an effort to establish relatedness; (3) Awareness of the importance of the therapist sharing thoughts and feelings that are commonly inhibited and might feel impossible to share, i.e., speaking the unspeakable; and (4) A stance that recognizes significant pain is often beyond psychotic symptoms and the losses inherent in the recovery process. These four principles can allow for the therapist to disrupt stereotyped ways of engaging. In this paper, the risks and benefits of these interventions will be analyzed that can keep treatments fresh, dynamic, and growth-producing.

Common Factors Leading to Impasse

Based on shared clinical experience, four common factors were identified that regularly lead to impasse in the psychotherapy for psychosis: (1) Incompatible agendas, (2) Role constraints, (3) Lack of common language, and (4) Stigmatizing attitudes. This is not an exhaustive list and different factors might lead to impasse in certain forms of therapy (i.e., CBT, psychodynamic, etc.).

Incompatible Agendas

When the therapist and patient begin the therapeutic relationship, they both bring explicit and implicit agendas into the consulting room. Sometimes the patient's agenda will be clear at the beginning of treatment (e.g., help reducing the voices) while other agendas might become more obvious over the course of treatment. Additionally, patients may have multiple agendas at once, which can be competing, contradictory, or complementary (Hamm et al., 2018). Therapists also have certain agendas about symptoms, suffering, and health that may be inconsistent with the patient's goals (Hasson-Ohayon et al., 2017). For instance, a therapist may be invested in trying to reduce voice hearing while the patient might take comfort in their voices, as they might offer much-needed company (Knafo, 2020).

These incompatible agendas often emerge when therapist and patient hold divergent orientations to reality. Therapists may approach divergent realities by attempting to persuade the patient to adopt the therapist's interpretation of reality or by withholding their own perspective on reality to build trust. Some persons experiencing psychosis might enter treatment with the hope of finding someone who will believe them and help them sort out their difficulty. For instance, a middle-aged man presented to therapy with paranoid ideas about the FBI spying on him at night. He slept with a machete under his bed in case he needed to defend himself. Sessions were filled with him detailing his nightly observations or sharing pictures he had taken to present as evidence to his therapist. An impasse could easily ensue if the therapist tried to adopt a counter position to convince the patient that his perceptions were unreal and simply projected, internal fears, which could lead to the patient feeling their deep concerns about their safety are being diminished. Sometimes therapists act as the arbiter of reality (Hamm et al., 2016) and adopt a "Columbo Style" approach (Tarrier, 2008) to provide education or arguments to dissuade the patient of their ideas. Even when offered in a context of support and compassion, such efforts can lead to an impasse, as often patients do not accept rational arguments against their psychotic ideas (Garrett et al., 2019). The therapist might feel increasingly helpless, as if treatment cannot progress in the face of the patient's rigid point of view and inability to entertain other perspectives. Alternatively, some therapists will try to remain "neutral" and merely focus on the patient's sense of reality while leaving theirs to the side. While this more patient-centered approach can be helpful in fostering empathy and trust, this stance leaves the patient alone with their confusion and might be unsustainable in the long run, especially if the patient asks: "Do you believe me?".

At the heart of these conflicts are different perspectives on reality that can lead to breakdowns in intersubjectivity, curiosity, and mutual reflection (Hamm et al., 2021). Therapists often try to navigate these difficult waters either by solely focusing on the patient's reality or by trying to impose their conventional interpretations of reality onto the patient. In the psychotherapy for psychosis, unacknowledged agendas

can derail treatment, especially when they are fundamentally mismatched. When therapist and patient begin working at cross-purposes, both parties can become increasingly polarized, and frustration can mount as neither feel their perceptions are validated and valued by the other.

Role Constraints

Patients may adopt a narrow focus in therapy because they are given messages that mental health professionals are only interested in their symptoms and may be less curious about the rest of their life. This belief is reinforced by mental healthcare systems that are more focused on reducing symptomatic distress and less grounded in meeting the needs of the person and "subjective aspects" of recovery (Lysaker et al., 2020). Subjective aspects of recovery include factors such a coherent sense of self, personal autonomy, and hope for the future. As a result, a patient might feel that it is their "duty" to maintain a focus on their symptoms, medications, and other aspects of their psychiatric identity.

In this context, it can be helpful to ask questions explicitly about roles and what the patient thinks is expected of them in therapy. Examination of the role of both patient and therapist can be valuable because these implicit expectations constrain possibilities and can lead to hiding or stereotyped patterns of relating. Therapists should also consider their understanding of their role (i.e., see Hamm et al., 2016 for common "roles") and how the patient might be exerting subtle pressure on them to assume a certain position (Sandler, 1976). A patient, for example, who addresses the therapist as the all-knowing sage might tentatively express their ideas and respond to the therapist's intervention as if they are filled with wisdom and deep insight. If the therapist does not reflect upon this dynamic and the role they are being recruited to fulfill, they might fail to analyze the underlying wishes and relational patterns that are being replicated in the therapeutic relationship. As a result, the patient might remain dependent on the therapist for guidance, which could ultimately prevent them from developing a sense of agency and belief in their own capacities.

Finding a way to relate beyond the role constraints of patient and therapist can be important but emotionally challenging. Bjornestad and colleagues (2018) noted that persons who had experienced psychosis expressed appreciation when the therapist was perceived as a genuine companion. All relationships, including the psychotherapeutic one are marked by this inescapable dialectic: people are struck between a desire to remain safe and hide and a wish to show themselves to one another (Will, 2021). Each part of the conflict breeds tremendous pain, as hiding can lead to loneliness while trying to connect to others may lead to anxiety about rejection. Both parties have trouble truly showing themselves, in part, because they do not know how they will be received and regarded. In response to this anxiety about being rejected, both therapist and patient can retreat to their respective corners. As Martin Cooperman once reportedly said, in psychotherapy the patient comes with his symptoms and the therapist with his technique and, if things go well, they both come out of hiding (Davoine & Gaudillière, 2004).

Lack of Common Language

Another factor that can result in therapeutic impasse is when the therapist and patient are not sharing the same language and understanding (Charles, 2012). Like all relationships, the psychotherapeutic one is ripe for misunderstanding and misrecognition. This can be driven by multiple factors. First, some researchers have considered psychosis not just a breakdown of thinking and perception but of language itself (De Boer et al., 2020). Persons experiencing psychosis often use words in peculiar ways, invent new ones, or communicate based more on the sounds than the meanings of words. This idiosyncratic use of language can be challenging for therapists to understand and requires close attention and a careful use of language to facilitate communication. Persons experiencing psychosis often have difficulty finding language to represent their psychotic experiences and may use therapy as a process through which they can find words to give form to their anomalous experiences (Bjornestad et al., 2018).

Psychotic symptoms often defy understanding and can stretch the limits of imagination. For instance, a young man was referred to residential treatment following a suicide attempt. In the weeks prior to the attempt, he had retreated into his room and was barely eating or moving. After months of therapy, he shared that he had smoked cannabis before the suicide attempt and had an "out-of-body experience" in which he had traveled to outer space and returned to his body as a "triangle" in the center of his chest. He asked if his therapist could help him extend to his fingertips because he wanted to become more embodied. Without listening on multiple levels (at the concrete, phenomenological level, and at the more metaphorical, interpretive one) to appreciate the various meanings of the patient's speech, the therapist might fail to understand the patient's use of language, which could contribute to a therapeutic impasse. For instance, if the therapist thought the patient was merely using a metaphor, they might fail to grasp the patient's altered sense of embodiment. Holding in mind both the concreted lived reality and the potential symbolic meaning of the patient's speech can deepen the therapist's understanding and prevent miscommunication that could lead to ruptures and, ultimately, an impasse.

Stigmatizing Attitudes

Another factor that often contributes to impasse is the persistent and insidious presence of the therapist's stigmatizing ideas about mental disorders as well as the patient's internalized stigma (Nabors et al., 2014). Persons experiencing psychosis are often thought of as fragile, vulnerable, and confused. These perceptions can sometimes result in stigmatizing attitudes that can cause therapists to avoid working altogether with this population because they do not believe that the patient can engage in meaningful dialogue. Additionally, therapists sometimes worry that therapy would expose the patient to undue distress and cause the patient to further fragment. For instance, therapists may be inclined to avoid exploring the content of a delusional idea because it might reinforce the patient's conviction (McCabe & Priebe, 2008). While there is some wisdom in these ideas (i.e., immediately challenging a delusion will likely go nowhere without established trust), these attitudes are grounded in the idea that persons experiencing psychosis cannot have a genuine conversation with another to help them sort out their chaotic experiences. As early as 1943, Federn suggested otherwise, arguing that patients with psychosis were eager to relate to the therapist and share all aspects of themselves, including strengths and successes. Viewing persons with psychosis as unable to think through complexity and consider alternative perspectives might deprive them of vital opportunities to develop more nuanced representations of themselves, others, and the world around them. As in all treatments, the therapist must tailor their interventions to the patient's developmental capacities (Brent, 2015) and avoid underestimating their ability for reflection.

Moving Together Beyond Impasse

Four central principles can be used to navigate out of an impasse: (1) An orientation to reality that honors intersubjectivity and the limited perspective of both patient and therapist; (2) Engaging vulnerably with an open heart to establish relatedness; (3) Speaking the unspeakable; and (4) A stance that recognizes that beyond the symptom is often significant confusion, loss of identity, shame, and grief. None of these four principles are exclusive to a particular therapy orientation. Taken together as follows, they offer therapists of different backgrounds strategies for responding to the patient's specific needs and the immediate circumstances unfolding in the psychotherapy and are broadly compatible with contemporary integrative psychotherapy methods (e.g., Metacognitive Reflection and Insight Therapy, Lysaker & Klion, 2017).

Intersubjective Orientation to Reality

Apprehending reality is an interdependent, shared project that requires a joint effort to name and describe reality, as best as possible. The thoughts people form about self and others are never constructed alone but occur between two minds or intersubjectively (Hasson-Ohayon et al., 2020). Intersubjectivity allows for mutual recognition and shared understanding of one another's subjective experience (see Hasson-Ohayon et al., 2020 for more detail). How the therapist positions themselves vis-à-vis reality is crucial when working with people experiencing psychosis, given that the patient is often struggling to make sense of the thoughts in their mind and the world around them. In the psychotherapy for psychosis, extreme perspectives can emerge. As mentioned earlier, on the one hand, the therapist can position themselves as "arbiters of reality" (Hamm et al., 2016) who try to "correct" the patient's reality distortions. On the other hand, sometimes therapists privilege the patient's point of view and set their own ideas to the side. Instead, it might be helpful for therapists to adopt a different stance in which they clearly state their perspective while acknowledge the limitations of what they know (e.g., a therapist cannot definitively claim to know the inner workings of the U.S. government) to avoid positioning themselves as the infallible expert. Fromm-Reichmann (1948) recommended saying to patients "I do not hear or see what you hear or see. Let us investigate the reasons for the differences in our experience" (p. 268). This straightforward position not only allows the patient to know where the therapist stands (while avoiding artifice) but also encourages a mutual exploration that prioritizes neither the patient's nor the therapist's view of reality. This position is consistent with the idea of maintaining an open stance, a non-controlling and inquisitive position that sets aside the therapist's wishes and agenda (Hamm et at., 2016). We view this stance as enabling conditions that allow for mutual exploration, a process that is ultimately the most relevant and therapeutic, rather than seeing the therapist's responsibility as convincing the patient of their view of reality.

The therapist's orientation to reality is especially relevant at the beginning of the treatment, as the therapist works to forge an alliance. For instance, a young woman was referred to outpatient therapy following her first psychotic episode and subsequent hospitalization in which she developed erotomanic delusions towards her professor. She had felt insulted by the nurses on the inpatient unit who told her that her thoughts were "unreal" and was thus guarded upon beginning therapy. She made it explicit in the first therapy session that she did not think she was psychotic and was therefore hesitant to explore her thoughts and feelings about her professor. Within the first couple of sessions, the therapist asked her about the meaning of the word "psychotic",

and she discussed how she felt her experiences were going to be dismissed as unreal and insignificant if they were labeled so. In these initial sessions, the therapist respected that patient's wish not to speak about her professor and asked general questions about her experience of the nurses and doctors in the hospital and how she felt she was regarded and perceived by them. With more time and trust, the young woman was gradually able to relax and speak more freely about her relationship with her professor and her confusing feelings. Over the course of treatment, it became apparent that her delusions about her professor were, in part, a reaction to losing her first romantic relationship and likely reflected her difficulty grieving this loss. However, in a different circumstance, it is easy to imagine that this young woman who insists that she is not psychotic might easily get into a power struggle with a therapist whose agenda was to convince her to accept the reality of her diagnosis. The more the woman felt pressured to accept the idea that her feelings about her professor were delusional, the more she might have dug in her heels and insisted that her therapist did not know what she was talking about.

Openheartedness and Vulnerability

Openheartedness, as defined by Galvin and Todres (2009) from a nursing perspective, includes a recognition of the nurse's inability to know the patient fully, an appreciation of the shared vulnerability and common humanity that unites nurse and patient, and an effort to practically respond to the needs of the patient in the moment using available technologies. Applied to therapy, a therapist who embodies openheartedness would hold their ideas about the patient lightly, appreciating that the patient is constantly evolving and never fully knowable. Therefore, the therapist would allow the patient to be separate and distinct from the therapist's picture of who they are. Second, the therapist would also address the patient with a recognition of their shared humanity. For instance, when a therapist listens to a patient talk about their fears of being attacked by others, the therapist could draw upon their own experiences of being hurt (though not necessarily disclosing them), allowing them to speak from an empathic position. In other words, the therapist can recognize that the patient's dilemma is a universal one, even if it is expressed in a more extreme form.

While openheartedness might foster authentic connection and mutual understanding, maintaining that stance is challenging. When people speak with one another, they, by necessity, often hold back their true thoughts and feelings to avoid misunderstanding, conflict, and rejection. This temptation is often intensified when speaking with persons experiencing psychosis who are hesitant to connect due to their potential histories of childhood trauma (Humphrey et al., 2022), fears of intimacy, and struggles understanding the other's point of view, which prevent relatedness. For instance, a middle-aged woman with chronic negative symptoms spent most of her sessions speaking about her favorite TV programs. She would often provide detailed descriptions of these shows with little commentary on what they meant to her. In response, her therapist would sometimes struggle to pay attention or remain curious about why the patient chose to spend sessions in this manner. In this context, therapists can emotionally shut down because of the patient's hidden manner and withholding of their personal needs and fears (Tillman, 1999). Speaking with an open heart might work to avoid falling into a state of emotional closure and could include a more direct comment such as: "Even though we've been working together for quite some time, I don't feel that I really know you all that well nor do I think you know me. I often get the sense that you would rather keep me at arm's length because you might fear showing yourself to me and it might not feel worth the risk. I'll admit that when you speak in detail about the TV show I often feel shut out and sometimes withdraw because I don't feel you're talking to me. I want to feel close to you, but sometimes I find it hard to open myself to you because I fear you're going to shoot me down and pull even further away."

Heartfelt interventions like this can feel risky because the therapist is trying to honestly share their thoughts and feelings. In these moments, the therapist does not know how the patient will respond and yet feels an urgency to try to speak the truth of their experience, as best they can grasp it. Of note, interventions like the one above also might need to be delivered over the course of various sessions and may need to be modified based on that patient's ability to make sense of complex reflections. Moreover, these types of interventions should only be offered to promote the therapeutic relationship, and the therapist should avoid disclosing personal details that bear no relevance to the patient's current dilemmas.

Given the intrinsic risk of speaking vulnerably, outcomes cannot be controlled. For example, a therapist had been working for years with a middle-aged man who consistently developed erotomanic delusions towards women. After going on an initial date, he would bombard his date with overtures of affection. If the woman did not respond immediately, he would send dozens of flowers to her. In one session, the therapist began thinking about the terrible dilemma the patient faced: his desperate need for love drove everyone away from him. In response, the therapist began to feel emotional and teared up. When the patient realized the therapist was moved, he asked the therapist what was wrong and the therapist responded, "I was just feeling terribly sad to think that your love is driving people away. It would be one thing if your anger or need for privacy kept others at a distance, but it's another thing when your wish to connect is too much for others." As the therapist began

to cry, the patient grew silent and expressed concern about the therapist's mental stability. Rather than opening a space for shared grief, the patient withdrew, leaving the therapist feeling exposed and insecure. Upon reflection, the therapist wondered if his emotional expression was felt to be too intimate. In many ways, the patient's delusion served to ward off intimacy—by turning the other into an object of obsession he kept at bay the other's frailties. This failed intervention is highlighted to illustrate the risk of being openhearted that exposes both therapist and patient to the possibility of rejection. However, this type of openheartedness can allow the patient to experience the therapist as a genuine companion (Bjornestead et al., 2018) who tries to bear witness while bringing themselves honestly to the relationship, despite the inherent risk.

Speaking the Unspeakable

While speaking with an open heart characterizes *how* the therapist speaks, speaking the unspeakable focuses more on *what* the therapist says to the patient. Therapeutic impasses often emerge when both patient and therapist feel unable to say the things they need to say. In relationships people often shield one another from their true opinions because they decide that the other person cannot receive the message. Sometimes this inhibition is borne out of experience (e.g., a friend who becomes dismissive when others notice his self-centeredness) and, at other times, it reflects a lack of courage. In other words, the person does not know if the relationships can survive a difficult conversation and potential hurt feelings. This dynamic is relevant for persons experiencing psychosis in two ways. First, persons experiencing psychosis have often received the message that family member and other mental health professionals do not want to hear about their anomalous or traumatic experiences. In therapy, they might hesitate to mention their symptoms due to internalized stigma or out of fear that the therapist will discourage them from talking about such matters or initiate an unwanted hospitalization. Second, when in dialogue with someone experiencing psychosis, the therapist might also feel unable to challenge (see Hamm et al., 2021) the patient's interpretations of their experiences due to concerns that it could lead to disagreement, rupture or, worse, decompensation.

In session therapists may struggle to know what they can say to the patient, which might inhibit deeper connection and understanding. For instance, a younger man presented to session by speaking uninterrupted for minutes on end about the U.S. Government. When the therapist tried to intervene, the patient would accelerate his speech and appeared frustrated by the interjection. Over time, the therapist felt irrelevant to the process and decided that it was easier to simply sit silently and wait for him to end. Furthermore, the patient often expressed feelings of hurt that nobody in his family would listen to him, which left him feeling alienated. In response, the therapist felt pressured to be different from how his family reportedly treated him. At times, the therapist began to believe that treatment was hopeless because of the patient's guardedness and considered decreasing the session to every other week. With the help of a supervisor, the therapist began to think about ways of sensitively introducing their own experiences while also respecting the patient's need to maintain control over the conversation. In a later session, the patient began by speaking about the latest conspiracy theory about vaccines, and the therapist noted he began to ready himself for another ten-minute rant. Instead, the therapist interrupted, "I have the sense that you care deeply about these ideas about vaccines which seem to upset and trouble you, and I know they are important. However, I also notice that I find myself starting to disengage when you begin talking about your ideas because I don't sense you are speaking to me, and I can't decide whether this is helpful or if you are hiding behind your political ideas to avoid more personal conversations." While interrupting this type of dynamic can be challenging and anxiety producing, it is vital that the therapist attempt to understand why both the therapist and patient are engaging in this manner. Without speaking the unspeakable, the therapist may withdraw and abandon the patient, leaving the patient to enact repetitive patterns that prevent self-revelation and interpersonal connection.

Recognizing the Pain Beyond the Psychosis

While people experiencing psychosis often feel tormented by paranoid ideas and persecutory voices, it is important to recognize that the reality beyond the psychosis is also challenging (Suchet, 2015). For example, recovery from psychotic episodes often requires contending with painful emotions such as sadness, shame, confusion, and grief (Ridenour et al., 2021). At times, therapists can be so focused on trying to help the patient adjust their orientation to reality that they fail to consider what is at stake for the patient. Three losses will be outlined that could emerge if the individual starts to integrate previously fragmented parts of the self and move beyond experiences of psychosis: loss of certainty, loss of identity, and loss of self-esteem.

Researchers have argued that persons who have developed structured, delusional systems are trying to organize a chaotic, confusing world (Sass & Byrom, 2015). Delusions may serve to simplify a shifting, perplexing world and limit a sense of overwhelm by interpreting reality through a very narrow prism. This stable position allows them to avoid what might otherwise be a highly fluid, unstable universe. Therapists ought to recognize that if the individual were to let go of their delusional system, they would have to sacrifice their sense of certainty and security in the world. Considering

new aspects of the self, others, and world requires confrontation with significant doubt, as well as a recognition that one's mind cannot always be trusted. This loss of trust in one's mind can produce terror and uncertainty that can lead to a painful sense of panic and existential dread.

Another central loss is the loss of identity (Buck et al., 2013). For persons who are experiencing psychosis, symptoms can provide them with a sense of purpose or meaning (Potik, 2014). Psychotic experiences can open up new horizons of meaning that are often experienced as personally significant and meaningful. For instance, a middle-aged man reflected upon his first psychotic experience when he was "told" by extraterrestrials that his mission in life was to become a painter. Over the next 20 years, he worked tirelessly to paint the perfect painting until he was eventually hospitalized for paranoia and an inability to function. As he began engaging in therapy, it was painful for him to recognize that his life course had been guided by a delusional idea that he no longer believed. Sacrificing these delusional ideas requires courage to face profound confusion and acute feelings of shame and loss. In this context, the therapist should welcome the patient's experience of grief while also respecting their need to turn away from such feelings of loss. When looking back upon the psychosis, the therapist might also help the patient explore the meaning of their symptoms, as symptoms provide important information about the person's fundamental concerns about their sense of self, interpersonal relationships, and worldview (Lysaker & Klion, 2017).

Finally, during psychotic episodes, people frequently engage in bizarre behavior and communicate messages to friends and family that they later find embarrassing. If the person emerges out of the psychotic episode, they must contend with these moments when they were out of control that can be an insult to their self-esteem. How people relate to these experiences is impacted by their recovery style (Ridenour et al., 2021), which influences whether people can bear to think about the meaning of their psychotic experiences and what it might reveal about their personal identity. Reflecting on these memories can produce shame, humiliation, and grief that could contribute to a depressive episode. As people grapple with these painful losses, they might begin to experience feelings of inadequacy and failure about their struggles to create a life they want. Awareness of these painful realities is often obscured by psychotic symptoms that can afford the patient a sense of meaning, purpose, and specialness (Potik, 2014).

Holding in mind these losses of certainty, identity, and self-esteem can enable therapists to recognize that the patient's resistance to developing insight is protective. When persons begin to emerge from a psychotic episode, they are often shaken by the experience and may have difficulty facing the reality of their situation, as it can activate doubt, loss, and shame. Recovery requires bearing grief, and some people might retreat from this pain by returning to symptoms that provide respite from the harsh realities of life. These various losses point towards the painful and protective nature of psychosis. As much as therapists might long for the patients to develop newer, more complex ways of reflecting upon their experience, they must also recognize that the road to recovery from psychosis is a hard one lined with grief, shame, and loss. Recognizing that symptoms not only not cause suffering but also protect people from other types of pain can enable therapists to maintain an empathic appreciation for the patient's situation. Nevertheless, recovery from psychosis is possible and learning to bear these emotional experiences is crucial to self-development.

Conclusion

While navigating out of an impasse is not always possible, these principles can help therapists regain their footing in moments when they feel lost. Asking the following questions might be helpful for self-supervision: (1) Are you too invested in your interpretations or lost in the patient's interpretations of reality? (Suchet, 2015); (2) When speaking with the patient, do you notice emotional guardedness that might be preventing more vulnerable relating? (Tillman, 1999); (3) Are there things you are avoiding saying to the patient because you worry that they cannot be taken in?; (4) What would the patient have to lose to make these developmental gains? Is it worth the cost? In moments when the therapist feels completely lost, supervision should be sought to help provide new perspectives and interventions.

Withdrawal from treatment remains an ongoing problem for persons experiencing psychosis and can lead to devastating outcomes (Kreyenbuhl et al., 2009). While previous research has emphasized the negative impact that lack of insight and incompatible ideas about the tasks of therapy can have on outcome (Startup et al., 2006), this paper described the additional interpersonal and therapist-related factors that might result in a stalled therapy that can lead to impasse. Furthermore, four principles have been outlined that can help both therapist and patient navigate beyond impasse: an intersubjective orientation to reality, openheartedness and vulnerability, speaking the unspeakable, and a recognition of the pain beyond the psychosis. These principles can promote respect for the patient and embolden the therapist to take judicious risks when treatments feel stuck. In addition, these principles encourage therapists to try to articulate difficult realities that, if continue to go unacknowledged, might derail treatment.

Funding There are no funding sources to report.

Declarations

Conflict of interest No potential conflicts of interests to report.

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