EJQRP (2023) Vol. 13, 186-203 ISSN: 1756-7599

European Journal for Qualitative Research in Psychotherapy
www.EJQRP.org
European Association for Integrative Psychotherapy

A balancing act – Therapists' experiences of conducting psychotherapy with psychosis clients

Jens Knutsson, Rebecka Jägestedt, Malin Persson, Jonas Ramner, & Eva Hoff

Lund University, Department of Psychology, Lund, Sweden *E-mail:* jens.knutsson@psy.lu.se

Abstract: This study aimed to explore therapists' experiences of providing therapy for people with a history of psychosis and examine the role played by psychotic symptoms in therapy. Interviews with 10 therapists were conducted and analyzed thematically using Interpretative Phenomenological Analysis. In the first of four themes, the therapists described a highly challenging work situation in which they first patiently needed to "unlock" their clients to lay the groundwork for an alliance. The second theme concerned the challenges of therapy for instance that, over the course of long-lasting therapies and under a recurring risk of psychotic contagion, therapists might temporarily lose their professionality, sometimes intentionally setting aside reality testing to assist their clients. The third theme encompassed the fine balance the therapists had to strike between strategies of supporting, to create safety, and confrontation, to aid progress in therapy. In the last theme, the therapists reported how using self-compassion and supervision as well as planning for recovery were crucial to cope with the turbulent process. Still, the therapists saw these therapies as interesting and remained fascinated by their clients, something that made their work highly rewarding. This knowledge about therapists' experiences can be used to inform students in training and to develop therapeutic work with this client group.

Keywords: Psychosis, interviews, therapist experiences, therapist professional development, supervision

T*herapy with psychotic patients involves "a subtle balance, because if I challenge them too much, they turn all their aggression towards me and that is hard to endure. Still, I have to do it."*

Research shows that people with psychosis can, in addition to antipsychotics and psychosocial support, benefit from psychotherapeutic methods such as cognitive behavioral therapy (CBT; Laws et al., 2018; The National Institute for Clinical Excellence, 2009; Turner et al., 2014) or psychodynamic therapy (PDT; Huhn et al., 2014) to improve psychosocial functioning as well as to reduce the stress that can be caused by psychosis (Zala et al., 2019). Psychosis is, however, characterized by a breakdown of the subjective and shared representation of reality, something which make therapy more difficult. Moreover, symptoms such as intrusive delusions, hallucinations, disorganized speech, affective flattening, and high levels of suspiciousness can complicate

communication about private experience. Also, clients with voice hallucinations sometimes experience threatening voices forbidding them to talk to the therapist (Cuijpers et al., 2019; Steel & Smith, 2013). A strong therapeutic alliance, where there is a sharing of thoughts and feelings, is likely to be an important aspect of all psychotherapy and the aforementioned difficulties can make therapy with people who are experiencing psychosis challenging. Even more, our limited understanding of how and "what it is like" to engage in psychotherapy during psychosis may be one reason why psychotherapy for psychosis is comparably less effective than for many other disorders (Fowler et al., 1995; Newton-Howes & Wood, 2013) We therefore believe that understanding and learning more about psychosis therapists' experiences, both in general and in connection to challenges and helpful strategies in their work, is of great importance. In the present study, and to this end, psychotherapists working with psychosis were interviewed.

Literature Review

Reviewing the literature, we found only four studies, briefly summarized below, focusing on the therapists' experiences of conducting psychotherapy for psychosis (Laufer, 2010; Lawlor et al., 2015; McGowan et al., 2005; Saayman, 2018).

In Laufer (2010), five psychodynamic therapists were interviewed about their positive experiences of countertransference in therapy with psychotic clients. She described a sense of personal growth experienced by the therapists that was spurred by unique experiences in therapy. Clients often came across as sensitive, uncensored and frank in their social interactions, and the contents of psychosis reflected their social experiences in a relatively unfiltered way. This sometimes gave rise to uncanny emotions in the therapists, but also made the relation authentic and resulted in a deepened existential understanding.

Lawlor, et al. (2015) interviewed 10 CBT therapists and eight clients, finding that clients often experienced paranoid thinking about their therapists and that signs thereof elicited self-doubt and vigilance in the therapist. Informants emphasized that a collaborative approach to psychotic experiences was helpful, including clarifying the client's grounds for the paranoia, rather than a confrontational approach. A change-oriented approach, however, including discussing paranoid beliefs with the client, was also successfully employed. The therapists described having to strike a thoughtful balance between these two approaches.

McGowan et al. (2005) interviewed four CBT therapists and eight clients about factors that affected the outcome of therapy. Although it had a different focus than the present study, this study nevertheless provides important insights: a sense of therapeutic progress was reported when the clients engaged in the therapists' models of reality, when clients' distressing beliefs (about symptoms) changed, and when reflective, logical thinking occurred, as well as when shared goals were established (McGowan, et al., 2005).

Finally, Saayman (2018) interviewed eight psychodynamic therapists with a focus on challenges in therapy for psychosis. The results were broken down into two themes: the experience of madness and the role of the body. The former described the therapists' experiences of limited thinking capacity and the breakdown of reality testing, while the latter included accounts of clients needed to be "held" (i.e., emotionally supported) by the therapists.

In addition, some psychodynamically-oriented single-case studies have pointed to psychotherapists' need to proceed cautiously in therapy due to their clients' vulnerability and struggling with feelings of incompetence when the psychotic world of the client was difficult to understand (McKenna, 2000; Terry, 2004, 2005). McKenna (2000) described how a therapist felt "lost in the words," unable to focus and break down the information into manageable parts, whereas setting aside reality testing and allowing a milder form of cognitive disorganization gave entry into the client's world, ultimately allowing for deeper engagement and understanding. In DiRocco and Ravit's (2015) study, the therapist similarly asserted that engaging in therapy with a psychotic client implied tolerating more chaotic aspects of the therapist's own psyche, allowing for some confusion. Letting go and losing hold of reality when relating to the client was necessary in order to follow the clients' experience more closely, so as to later reflect upon it and render it comprehensible. By questioning the client's reality, the therapist risked being perceived as authoritarian and disrespectful, and thus damaging the therapeutic relationship (McKenna, 2000).

To summarize, previous research on therapists' experiences of providing therapy for psychosis has shown that clients can be perceived as sensitive, inspiring caution in the therapist (Terry, 2004, 2005) and has highlighted the challenges of collaboration for example shared goals (Lawlor et al., 2015; McGowan, et al., 2005). This research has also demonstrated the importance for therapists to handle delusions and disorganized thoughts with flexibility, experiencing and tolerating their own confusion, and even momentarily setting aside critical thought in order to follow the client (DiRocco &

Ravit, 2015; McKenna, 2000). That said, the research also found that clients, as well as therapists, believe that supporting critical thinking in therapy (Lawlor et al., 2015; McGowan, et al., 2005) while avoiding being authoritarian (DiRocco & Ravit, 2015) is crucial for making therapy for psychosis work. Finally, the cited studies also emphasize the need for therapists to be able to handle feelings of incompetence when progress is slow and the client is difficult to understand (Terry, 2005; McKenna, 2000).

Although the studies discussed above clearly have contributed to an improved understanding of how to conduct therapy for psychosis, they are limited in that they were carried out within certain therapeutic approaches and focused on selected concepts, processes, or outcome factors. Considering these limitations and the presumed importance of common factors in therapy (e.g. Wampold, 2015; Newton-Howes & Wood, 2013), including shared understanding and a strong therapeutic alliance, we argue that important additional insights could be gained from interviewing therapists from different theoretical backgrounds about the more general aspects of their experiences. This knowledge will be essential as a means for improving current treatment and helping prepare therapists in training and those about to begin working with these clients and may provide recognition for those presently working with psychosis patients.

Purpose

This study aimed to explore what it is like to conduct therapy with individuals who have a history of psychosis and what role clients' psychotic experiences play in therapeutic work. The specific research questions were:

1) How do therapists define the characteristics of therapeutic work with clients suffering from psychosis?

2) What challenges do therapists describe in therapy with these clients?

3) What strategies and approaches are experienced as helpful in therapy with these clients?

4) How do these therapeutic experiences play a role in the therapists' professional development?

Methodology

Participants

The researchers recruited a sample of 10 therapists (five women and five men) who were selected for interview on the basis that they were qualified clinical psychologists and had at least 1 year of clinical experience with psychotherapy for psychosis. Their therapeutic training was either Psychodynamic Therapy or Cognitive Behavior Therapy. Five informants were invited by contacting the staff of psychiatric psychosis clinics in Sweden. In addition, members of a therapeutic organization were asked to participate. Snowball sampling was used for the remaining informants, meaning that those taking part recommended others. The therapists had between 1 and 40 years of experience with therapy for psychosis and were both younger and older therapists (age range 45 years).

Researchers

The research team consisted of two senior researchers: one with extensive experience of conducting therapy with psychotic clients and the other with methodological experience with qualitative research. The three authors who conducted the interviews with the therapists were students from the clinical psychology program attending their final year.

Materials and Procedure

The interview was semi-structured and consisted of open-ended questions intended to encourage the therapists to describe their experiences in their own words. First, some background questions were included concerning age, training, and work experience with psychosis. Next, came questions concerning the therapists' first session with a client with psychotic experiences, their general experiences with this client group, and what role this work had in their lives. A series of questions followed about concrete occasions when the therapists' experienced difficulties or breakthroughs, more and less helpful aspects of therapy, and the emotions therapy evoked. Finally, there were questions regarding specific therapeutic relations that had affected them deeply.

The study was approved by the Regional Ethics Review Board (No 2016/650). Participants gave written informed consent

before the interviews and were informed that they could withdraw from the study at any time. The interviews lasted approximately 1 hour and were audio-recorded and transcribed verbatim. Most took place at the clinics where the informants worked (the exceptions were two which were conducted in the informants' homes and one which took place on campus). Informants were assigned gender and age neutral pseudonyms in the transcripts to ensure confidentiality during storage of data, the senior researchers' analysis and in publication of the research. In addition, the quotations were scrubbed of any identifying information.

Interpretative Phenomenological Analysis (IPA) was used for data analysis. IPA aims for detailed exploration of respondents' understanding of their lived experiences, and the method recognizes the fact that the researchers interpret, based on their specific life experiences, the informants' interpretations of their experiences (Smith, et al., 2021).

The following five steps were employed by each author working separately: First, a close reading of each transcript (one at a time) were done while writing three types of exploratory notes (Smith, et al., 2021; Smith & Fieldsend, 2021): (a) descriptive (experiences described); (b) linguistic (participants' use of language and its significance); (c) conceptual (implicit meaning hinting toward interpretations and underlying assumptions). Secondly, all exploratory notes were re-read and compared in order to formulate a set of themes within the case, so called experiential statements. Third, tentative master themes for the interview were developed. Fourth, the same procedure was repeated with all transcripts. Lastly, each author investigated patterns across cases arriving at a final structure of subthemes and master themes. In this process, the relations between the themes were analyzed, and some overlapping themes were merged. Among the authors the three junior researchers made the preliminary analyses directly after having held the interviews. Then the two senior researchers repeated the analysis procedure (within and across) to decide upon a final structure, taking the junior researchers results into close account. The final structure was scrutinized by the junior researchers separately. After each resulting subtheme, we added a brief interpretation, aiming to highlight the meaning of the theme in question.

Reflexivity

In an interview context, experiences are remembered and told in an interpersonal meeting between the participant and the interviewer, which means that more is taking place than mere data-collection. Among factors that may flavor the interview situation are the fact that the interviewers and the informants did not know each other before the interviews, that the interviewers were well acquainted with the work tasks and processes described by the respondents, and the fact that the interviewers were psychologists in training and the informants licensed and practicing therapists. A reflexive stance was taken in the work process to be aware of and admit the role that the researchers played for the presented results, but also recognizing that it was an asset in the interpretation of the informants' experiences (Olmos-Vega et al., 2022).

Findings

The thematic analysis of the therapists' experiences of conducting therapy for psychosis produced four major categories: Laying the Groundwork for Therapy; Constrained Therapists; A Fragile Framework for Therapy; and Professional Doubts, Growth and Restoration. Each category was further broken down into three or four subcategories (see Table 1).

Main Categories	Subcategories
Laying the Groundwork for Therapy	Establishing contact Expressing genuine emotions Sharing wordless experiences
Constrained Therapists	Being shut out Getting stuck Getting sucked in Miscommunication & broken confidences
A Fragile Framework for Therapy	Supporting someone fragile Weighing one's words Challenging the client in service of the therapy
Professional Doubts, Growth & Recuperation	Self-doubt and fears Professional growth Challenging & satisfying work

Table 1: Main and Subcategories of the Therapists' Experiences of Conducting Therapy for Psychosis

Laying the Groundwork for Therapy

The therapists often characterized the client group as difficult to reach and form relationships with. Thus, establishing any contact was an important first step in therapy. To that end, the therapists talked about the importance of embracing and expressing genuine emotions, as well as sharing experiences with their clients.

Establishing Contact

The therapists described difficulties establishing contact with their clients. Different ways of reaching them included showing prolonged patience or engaging in shared activities. Some reported that explicitly talking about psychotic episodes led to improved contact. Among the reasons cited as causing difficulties were the clients' coming across as reluctant or having difficulties expressing emotions. Terri, among others, found that someone "who isn't keen on expressing their emotional life, really makes it hard to establish contact. They hold onto their inner selves like Fort Knox." Other reasons mentioned were the self-reliance practiced by those with psychosis as a way of avoiding risk. Tyme explained, "Psychosis is a condition where you withdraw into yourself, into a fantasy world. You get self-sufficient, not needing relationships." He further commented that a client might "renounce [relationships], as they have become threatening and dangerous. So, I have to conduct therapy with a person who either believes that everyone is out to get them or that relationships are meaningless."

Nevertheless, the fact that the clients actually showed up for therapy was interpreted as a need to connect. Tarian remarked, "All human beings seek contact. The patients *do* come voluntarily; it is quite obvious that one part of them wants contact. At the same time, they resist real contact. But there is a longing [for contact], otherwise they wouldn't come." To tackle the commonly experienced difficulty of making contact, the therapists had different suggestions. Tevin described how he practiced perseverance: "I often say that I can relate to a stone. You must work incredibly hard to establish a relationship. So, it's up to you to keep on inviting, inviting and inviting." Some therapists talked about the importance of common interests (e.g., music or art) as a means of establishing contact, or engaging in activities the clients enjoyed (e.g., playing table tennis or chess). Tai described this:

> A patient was referred to me by a colleague, as she knew that I was a musician. So, the patient knew beforehand that I played. It went very well, we shared references. We could move freely in the world of music, using terms of audience, chords, harmonics, and performances. It increased opportunities for contact.

Although clients were often cautious due to previous negative experiences, some therapists described sharing the experience of psychosis or explicitly talking about it as a way to connect. Such sharing could be a sign of trust, as Taffy explained: "I would say that a deeper contact is established when the person shares their psychotic experience. It's a beautiful thing to be let in on that, when someone starts sharing private experiences that they've kept to themselves for a long time." Tory talked about one occasion when therapy progressed after a client disclosed psychotic experiences: "You told me about these voices. You never told me, even though we've known each other…" The client smiled and said, "Of course I haven't told you! You would think I was crazy!" Afterwards, there was a breakthrough: the therapist gained deeper access to the client's inner world, beliefs and feelings.

An interpretation here is that some symptoms of psychosis, such as difficulties in communicating emotions and experiences, in combination with previous negative experiences of sharing, limit the clients' ability to establish meaningful therapeutic relationships. In the initial stages of therapy, it is therefore important to creatively find ways to establish contact. Building enough trust to create an actual working therapy alliance might take several months, and the first crucial step seems to be to help the clients lower their guards.

Expressing Genuine Emotions

The therapists stressed the need to share both positive and negative feelings with their clients in order to facilitate the therapeutic process. This also involved being transparent about their own emotional reactions to avoid misinterpretation by clients. Several therapists also learned that a neutral position, commonly employed in therapies with other groups, could be particularly difficult for this group of clients. Tai asserted:

> [As a therapist,] trying to be neutral and clinical, never showing what you feel, fearing your feelings... People do read each other. I don't mean that you should be a ticking bomb, but if there is anger, the body language will tell. And psychotic patients need clarity.

Furthermore, since the clients hold their own emotions back, they could be helped by the therapists modeling the healthy expression of feelings. These feelings were sometimes reflections of the client's emotions; for example, Terri found,

"My anger connects with the patients' anger, which they have difficulties expressing. You invite them to your own emotional world when being human or getting emotional. I'm not sure being too downplayed is advisable." Expressing positive emotions, especially shared ones, were also perceived as helpful, as it created a bond. Tiger remarked:

> When the patient laughs and you laugh, something happens: the patient feels a lot better. There's affinity in laughing together, it's wonderful with that sense of belonging. Having access to humor means having access to your inner reality and intellectual capacity.

A few therapists described losing their temper with clients. This was helpful rather than harmful, provided their reactions in the situation was resolved and rendered intelligible. For instance, when a client knocked on Tai's door several times despite being told repeatedly that the red light meant no interruptions, Tai confessed:

> The third time [the client knocked], I don't know what happened, I got furious: "Damn it, haven't I told you that you have to leave that [door] alone." And the patient says: "Can you get angry at me?" Then suddenly we had a real connection, the person looked at me. We connected. And it was vital.

Disclosing private matters was recommended by some therapists in order to foster transparency and help clients' reality testing, preventing unnecessary worries. As Terri expressed it, "It is like children's fantasies, they are often worse than reality." For instance, Terri told a client when a relative had died: "I have illness in the family; that will not influence our work, but maybe you will notice it affects me."

Our interpretation is that due to the emotional difficulties and sensitivity of many clients, the therapists authentically expressed their own moderated positive and negative emotions. Such emotional sharing appeared to promote the therapeutic process. Even expressing frustration towards clients may help the clients to understand emotions. Overly emphasizing the appearance of neutrality seemed to risk undermining the alliance, as these clients easily misinterpret interactions in which the intentions are not clear.

Sharing Wordless Experiences

During therapy, experiences that were difficult to express in words (e.g., feelings of sorrow, fright, frustration, confusion, and emptiness) were shared. Episodes of sharing were more felt than understood at the time they occurred. Sharing emotions was common, as in Tarian's example: "You get engulfed when the room is filled to the brim with fear and horror, it's something that's hard to grasp that we both must endure." Therapists also had wordless physical experiences, such as experiencing a sudden headache. When clients appeared to be emotionally shut down, it caused strong reactions in the therapists. Sometimes the emptiness gave rise to frustration or fatigue as Terri expressed:

> I get so tired. I have to pinch my hand and bite my tongue. It feels like I'm toppling over, struck by some sort of exhaustion. But still, here is a person who has experienced terrible things in life. I sense some sort of endless sorrow and despair. When I get tired like that, I often find myself thinking that they keep a profoundly depressed part hidden inside them.

Another common experience—sometimes associated with discomfort, but nevertheless important for reaching a deeper understanding of the client—was when the therapists "let go" and became entangled in the client's inner world. Trapper talked about being with the clients in their chaos:

> It's a breathtaking experience, like standing on the edge of a cliff. "Oh!" You can sense the abyss. Somehow, you need to embrace it, to show that I am with them. You need to be part of the chaos for a while, before starting to sort it out to understand what it is all about. [You must], so to speak, ride along on the patient's merry-go-round.

When feeling their own grip on reality was fading, the therapists were able to understand what was happening to their clients during therapy. Tiger said, "I can feel that your reality is faltering, because I can almost feel that my own reality is faltering."

An interpretation here is that it seems that the therapists' sharing of wordless experiences, though at times difficult to endure, increased their understanding of their clients. By sharing the clients' experiences and displaying their own emotions in the moment (as well as their abilities to handle them), the therapists could help clients verbalize, manage, and work through emotions.

Constrained Therapists

The therapists described different situations that made them feel constrained, feel shut out, become stuck in therapy, or they found themselves in a paralyzed position, with little control of the interaction. Additionally, several respondents reported feeling sucked into or confused by the clients'

psychotic worlds, sometimes momentarily losing their own grip on reality. Lastly, miscommunication and broken confidences also occasionally challenged progress in therapy.

Being Shut Out

Almost all therapists described occasionally feeling shut out. This occurred predominantly in the early stages of therapy, but sometimes also in therapies that had been going on for a long time. Feelings of impatience or sleepiness were common in these situations. In Terri's words, "When you meet a patient that shares very little of themselves, it's like trudging around in porridge and you have no idea if it will lead to any result at all." Being shut out could also drain the therapist of energy. During prolonged passages of silence and low energy in therapy, Tai felt fatigued and fantasized about falling asleep:

> Suddenly the thought appears: "what if I can fall asleep with one eye! I sleep with my left eye. The patient sees my right eye, which is awake. But really, I'm asleep." I noticed dreamlike thoughts appearing, as happens when you are sleepy.

Tyme and a few others described having to resist the urge to avoid difficult wordless experiences when feeling shut out:

> One of the mistakes I make repeatedly is to be too active. You do a lot of things to keep therapy running to avoid something frightening. It's hard to sit still with an individual who presents an inner landscape in ruins.

Our interpretation is that being shut out might cause the therapists to feel less engaged and give rise to frustration and a loss of energy. This position implies a sense of struggle between therapists and clients: a shut-out therapist may resort to eliciting reactions to avoid involuntary emotional contagion.

Getting Stuck

Many informants mentioned therapies where they felt "stuck," with little sense of free will or ability to decide how to proceed. During such episodes, the basis for feeling and thinking freely felt impaired. The therapists used metaphors to describe this state, saying they felt "pinned to the chair" or "painted into a corner." To illustrate how being stuck felt, Tevin recalled a particular occasion:

> The patient started right away to tell me about the patient's dreams, which is quite unusual. And for these dreams, the patient already knew all the answers. There was a growing feeling that the patient directed our meetings, that everything was pre-planned. I felt a growing sense of panic about what would happen if I didn't follow along—I felt the straitjacket on my back.

In similar situations, some informants felt limited to a sort of atheoretical, passive listening, unable to make sense of the clients' experiences. For instance, Tyme talked about feeling "cognitively disabled," experiencing difficulties theorizing about what occurred in therapy over several sessions: "What are you supposed to do then? Well, you really should ask for supervision, but of course I didn't think of that either." Moreover, the experienced influence of the relationship could be felt both in sessions and in the therapists' private lives. Taffy remembered a therapeutic relationship with a powerful impact both during and outside of sessions: "I felt that my own sense of well-being was linked to this patient. If the patient felt worse, I felt worried and frightened. When the patient felt better, I felt content." Another type of constraint was the experience of a loss of willpower. Terri remembered feeling mesmerized:

> Suddenly, I feel hypnotized almost. It's like if I don't watch out, my brain will shut down, like turning off a switch." She remembered saying to herself, "'Turn on some lights or we're both lost!'" She continued, "[The client's] suffering is endless. The client sucks out my entire life force, because the client needs it. But it doesn't work, because then I can't continue to give.

Our interpretation is that the therapists occasionally seemed to experience getting stuck or trapped in therapy, which involved momentarily losing their ability to reflect or access their theories and professional tools. An important issue for them was how to handle these experiences in a way that fostered therapy without sacrificing their agency.

Getting "Sucked In"

Most therapists sometimes felt sucked into their client's psychotic worlds, experiencing an altered sense of self, surreal experiences, a momentary loss of their own reality testing, or being subject to the clients' paranoia. In these instances, some felt paranoid themselves. As an example of getting sucked in, Tai described a state of confusion with one client: "I said something, and the patient responded 'Oh, what did I think now?' It was interesting, because it continued, always returning to the question of who affected who's thoughts now?" Also surreal experiences of fragmentation or a sense of influence from the clients' psychotic experiences occurred. Tory explained:

> This inner chaos and being dissolved is something different. You sense the patient's schizophrenia all the time, it lacks

> boundaries: We both get dissolved. We talked about the patient's parents and suddenly everything went quiet. I felt I cracked open: my chest opened wide. It was horrible. There was a hole, and it was like light came right through me. It was not like seeing guts, only that it felt like "now everybody can see everything."

Several informants reported being subjects of the clients' paranoia and becoming paranoid themselves, with loosely grounded suspicions. Tory described this in the following way:

> I had this paranoid and somewhat dangerous patient. Once, when I went out to buy lunch, I felt uncanny, like someone was following me. Entering the salad bar, I had a feeling of being monitored. I recall wondering why, and when I had supervision and told my tutor he just laughed and said, "You didn't suspect it was one of your clients?" And I saw it clearly. "Of course, one of my patient's shadows people from his car!"'

On a similar note, Terri conveyed that she once felt compelled to end a therapeutic relationship because the client experienced her as malicious. The constant confrontations wore Terri down, and they were forced to withdraw to be able to function and be available to other clients. At the same time, terminating the therapy elicited a sense of guilt for letting this client down and experiencing some of the maliciousness the client had attributed to Terri.

An interpretation here is that getting sucked in involved a momentary loss of reality testing for the therapists that made it difficult to draw clear boundaries with the clients regarding the origins of experiences, feelings, and thoughts. The informants were surprised by how strongly they were affected. An important aspect in therapy for psychosis is to be able to reflect upon these experiences through supervision.

Miscommunication and Broken Confidences

The therapists reported that due to the clients' difficulties in explaining what they meant and problems understanding the therapists' intentions, misunderstandings commonly occurred, sometimes leading to termination of the therapy. Tevin shared an experience of miscommunication when trying to make a client conscious of how their fear was related to gradually losing control and not having strategies to regain it. The communication was misunderstood, however, and led to more suspicion:

> I said that it would be good for the patient to rearrange things, which the patient understood as I would 'make the patient deranged,' that I tried to make them crazy. This [misunderstanding] reoccurred on several occasions, as a fear of me intending to actually harm the patient.

Some therapists also recounted occasions of broken confidences, in which clients felt disappointed or even humiliated when the therapists tried to convey that the clients' disclosures of their "true experiences" were in fact evidence of them suffering from psychosis. Tory felt that knowing when to challenge clients is complicated:

> Delusions are the most difficult. It's impossible to talk about the problem, as it is *part* of the problem. If I question the patient's beliefs, the patient will discard me because then I am just like everybody else. The patient might never come back or even hate me, turn their aggression on me. It's really hard to endure and we risk losing the alliance, and if we do, there is nothing left.

On a similar note, Terri experienced a client quitting therapy when gently confronted: "The patient was so deeply offended when I asserted that this wasn't real that the patient quit"

Sometimes the therapists had special insight into their clients' lives through therapy. This position at times led to feelings of betrayal when delicate information had to be shared with other professionals against the clients' wishes when, for example, symptoms worsened or the clients stopped taking their medication. In those situations, the clients' openness and trust in the therapists could lead to what might be perceived as punishments, such as hospitalization. The therapists might feel that they "went behind the back" of their clients, betraying their confidence. Tonie, after alerting another professional, remembered, "I felt guilt, failing to remain the person I was for the patient. Someone who was on their side suddenly became someone else." Taffy felt the treatment system sent mixed signals to patients with psychosis:

> Like it or not, you work in a fairly rigid system, not always encouraging sharing the psychotic experiences. If you [the patient] stop talking about it [the psychosis], you don't need to be here anymore. If the patient successfully hides their symptoms, they could be discharged.

Our interpretation is that when there was a misunderstanding or broken confidences, it appeared to be hard for the therapists to maintain a healthy alliance with their clients, especially when the therapist was the client's only confidant. When disclosed information must be questioned or shared outside therapy in service of the client, the issue of having to betray the client's confidence created a dilemma, giving rise to therapists feeling inadequate.

A Fragile Framework for Therapy

To make therapy work, the therapists recounted how they had to tenderly handle fragility and uncertainty in their clients, creating a feeling of supporting someone fragile. During sessions, the informants also described weighing their words so as not to offend the clients and imperil the relationship. Still, the respondents stressed that to help the clients, they also felt obliged to challenge them in service of the therapy.

Supporting Someone Fragile

The oft-described fragility of psychotic clients played a role in the therapists' perceptions of what the clients could manage in therapy. In their efforts to make the client feel safe, the therapists used different ways of supporting them. Psychologically, they conveyed warmth, offered constructive approaches to common problems, or acted as role models. Physically, the therapists' body language, voice, or gaze instilled safety. Enforcing clear boundaries in therapy was another way of providing support. In terms of psychological support for clients, Tonie explained, "I instinctively feel it is very important to support them and create safety. There is something fragile, a big fear, which is important to handle, something skittish that makes the relationship so important." Terri described the role model form of support extending beyond sessions: "I'm part of the patients' inner worlds, they tell me. [One client said,] 'I try to think what Terri would say, then you say something to me inside my head.' Those voices are good, they influence the patients' approach." In other words, Terri modeled a way of thinking in therapy that the client was able to use in their life outside therapy. Also, the physical presence of the therapist could convey safety. For instance, Terri described how her soothing voice "supported" one client: "One patient said: 'I like your voice.' I don't think the patient heard what I said, the patient just listened to my voice." Tai had a similar experience with eye contact:

> We sat quietly and gazed at each other, and it felt really strange at the beginning. Then eventually I started to recognize the gaze. I have children, [and when] giving them the bottle, they look persistently. I recognized that gaze.

Maintaining clear boundaries in therapy was another aspect that could provide a sense of safety. Tiger noted, "The therapeutic space, the boundaries around it, have a supportive function—it creates a safe foundation for therapeutic work." Furthermore, in the process of establishing a strong, supportive relationship, the therapists gradually became very important figures in the clients' lives. A few informants pointed out that they probably were the first person that the clients confided in, which was perceived as implying a lasting responsibility. For instance, Terri stated, "You are morally obliged to be prepared to stay for a very long time." Before vacations, for example, it was described as important to reassure the client that the contact would continue after the absence. Otherwise, there was a risk clients might fantasize of being a burden and fear rejection. Tiger gives an example: "I tell the patient that I'm back the 18th of August, then we'll meet again, and write it in my calendar *with* the patient. It's about clearly showing, 'we'll meet again, I can cope with you'."

Our interpretation here is that most therapists tried to be explicit, tender and careful in order to build a fruitful relationship with their fragile clients. Both psychological and physical scaffolding appeared to make it possible for their clients to handle their fears of rejection and talk about and process difficult subjects. Support could be an internalization of the therapists' voice, eye contact or approach, which soothed and guided the clients in different situations.

Weighing One's Words

During periods of psychosis, the clients' awareness of their illness was often limited. The therapists described sensing a risk of harming the relationship or even triggering psychotic symptoms by being careless. They used metaphors such as "feeling like a bull in a china shop," "walking on thin ice," and "tiptoeing" to express this. Many informants mentioned that designating experiences as psychotic was risky, even when the relationship was strong. If the client did not share the therapist's view, the client could experience this as being doubted. Almost all the informants mentioned carefully considering how and when to share their thoughts with these clients to avoid confrontation, more so than with other patient groups. Terri described it as "like walking on a minefield. It is incredibly delicate." Different strategies were employed to work around confrontation and make talking about delusions possible or less risky. Exploring psychotic experiences, while neither questioning nor affirming them, was described as one tactic. For instance, Terri said, "I try to relate to them [delusions] as *their* experiences and perceptions, not discuss what is real or not. It can be very delicate." Tiger described trying to agree on having different experiences:

> I say, "I get that this is difficult, but that is not MY experience of reality. My experience is different, can you relate to that?" Usually the patients can, they are aware, but may still feel some anger. "You always have to be so reasonable!"

Similarly, some of Terri's clients accepted her reality, i.e., when Terri offered rational explanations of their psychotic experiences, while others protested: "'What do you mean MY reality? It's THE reality!'"

An interpretation here is that it seems that the therapists' weighing of words and selectiveness as to what to share were necessary to maintain their clients' trust. The need for the informants to maneuver around the clients' delusions and paranoia slowed down therapy and tested the therapists' patience. This careful "easing in" on important subjects appeared to be essential to avoid colliding with the clients' perception of the world or making them defensive.

Challenging the Client in Service of the Therapy

While stressing the importance of being cautious, non-confrontational and supportive, several informants also pointed to the risk of becoming stuck in a solely supportive role. Despite clients' limited awareness of their delusions, most therapists felt that their clients had some insight into their illness, and that not challenging delusions could hinder progress. The therapists perceived that the content of the psychosis provided meaningful clues to the client's experiences. Some therapists even described the clients' involvement in their psychotic worlds as a way of protecting themselves from experienced trauma that needed to be uncovered. Tevin explained that psychosis might be "The only defense mechanism that the person has been able to employ, to hold something truly and intensely unpleasant at bay." Though difficult, several therapists reported that challenging the client was necessary to move forward in therapy. Taffy saw addressing delusions as necessary:

> Shouldn't I challenge their ideas? If I don't, we survive, have a good time. *But*, if I accept something pathological [and] do nothing, some part of the patient will feel deeply betrayed. Still, if you speak up, the patient might quit.

Moreover, talking about psychotic symptoms could be an engaging experience for the clients, as Tevin related: "To verbalize your psychotic experiences is not always frightening; rather, many enjoy that someone finally dares to speak to them about them. Their symptoms are highly meaningful." The therapists also asserted that most clients, at least in part, were aware of their difficulties, and felt relieved when these were openly addressed. Tevin stressed, "Nearly all psychotic persons know... I've realized that there's some kind of insight in that 'I know these are unusual experiences, I can understand that you don't share them with me.'" Some therapists admitted that they sometimes exaggerated the risks of challenging their clients, even if the risk of triggering anger or stress did, in fact, exist. Thus, the informants perceived the balancing act between supporting and challenging as difficult, but also crucial. Terri, for example, had an experience where the limit was reached with one client, causing the therapist to speak up and thus the client to progress:

> The patient had a really difficult childhood and was abused. The patient was jealous and felt that society should help. The patient was to be compensated. And one day I had enough and said: "I will make it clear to you, that you need to get out on the field and sow, and *then* you harvest! And then you make your own bread! Otherwise, you'll starve to death!" The patient was flabbergasted but took it well. The patient understood precisely what I meant. "Stop it! It's up to you, do something yourself!"

It was not appropriate, however, to challenge every client. The duration of therapy and the clients' current state of stability were brought up by a few therapists as important aspects that could be of importance for whether the confrontation was successful. Terri reported, "Most patients have more stable periods when they can put words to and understand what emotions fuel their psychosis." But, even for clients who had made progress, some instability remained.

Our interpretation is that challenging clients appeared to be especially difficult after long periods of merely supporting and building trust. Nevertheless, the therapists needed to help the clients mitigate the impact of psychosis, explicitly calling out non-shared experiences and assigning the clients certain responsibilities for their own recovery. Without challenging, it was difficult for clients beginning to understand the subjective meaning of their experiences and accept that a reality-oriented view could be beneficial.

Professional Doubts, Growth and Recuperation

Despite ample professional experience, all informants reported experiencing self-doubt and fears in relation to their work with these clients. Several therapists revealed that early in their careers, they had exaggerated expectations that therapy could lead to full recovery. With professional growth, their expectations became more realistic. Finally, the informants stressed the necessity of recovering from the challenging therapies, but at the same time expressed how interesting and fulfilling they found their work.

Self-doubt and Fears

Progress in therapy was often slow and the clients' responses in therapy were sparse. The informants reported feeling insufficient and sometimes lonely. Many experienced feelings of fear, guilt, and being clumsy or odd. Some informants reported that the lack of response from clients could create a sense of failure. Tyme shared one experience:

> Not getting anything back from this patient, like: "Yes, you're right about that!"" "That's useful!" There was just: "No... no...." … though it wasn't belittling, like "you're a complete fool," rather it was a kind of discounting of everything, which frustrated me. I never got any confirmation.

Doubts also sometimes arose when the therapists did not feel sufficiently engaged; for instance, on occasions when they were unfocused or tired. Tory revealed how this could evoke self-accusations:

> I feel: "Get a hold on yourself!" In the afternoon, I can get tired—it's nothing strange, but I have a bad conscience. And it's a bit taboo; you should always be a good [therapist]. Some patients, I feel less engaged with, and that's awful.

All informants mentioned that they at times questioned their capability as therapists. Taffy expressed this as follows:

> Doubt, that's what we do. Thoughts like: "You don't need to come here and see me, you should do something else instead, and then you'd be better off. Or should we adjust your medication?" I have struggled hard with feelings of powerlessness.

Tonie also described a taxing treatment where she felt "The fear of not being sufficient, and I wanted to give everything. I had strong negative feelings about that, too. I could feel nervous, worthless and inadequate." Other types of emotions were also mentioned in relation to self-questioning. Tai expressed feeling weird at times when working with clients who had unusual experiences: "You think that you are odd yourself. 'How could I think like that? Oh no, what a ridiculous, perverted thought!' In the beginning, I could feel lonely in this." Terri sometimes felt clumsy when challenging clients: "It's easy to feel horrible when you set limits—everything feels so vulnerable. I sometimes feel like an elephant in a glass house. With these patients, I have more self-doubt."

Our interpretation is that feelings of inadequacy appeared to be common among the therapists, possibly because psychosis is difficult to treat and negative symptoms are particularly challenging, making response and feedback difficult. Feelings of insufficiency created self-doubt, especially in the face of a lack of clear therapeutic progress.

Professional Growth

At the beginning of their careers, several of the informants reported having exaggerated expectations of the effects and progress of therapy, as well as in their view of themselves as therapists. With increased experience, they became more realistic and less self-critical. All therapists described growth. For example, when starting out as a therapist, Tarian's faith in therapy was complete, which created a blind spot:

> You can save the world! I was completely convinced that [therapy] is the most beautiful thing you could give to someone. I was not observant of what people really needed—rather, I was preoccupied with what I wanted to give.

The therapists stressed that over the years, they had adjusted their expectations and accepted their limitations. Tyme learned, "You really have to aim for completely different goals that are much more realistic. In most cases, you have to be happy if the patients can live fairly decent lives, avoid hospitalization and experience fewer psychotic episodes." The therapists noted that unrealistic demands actually got in the way of genuine contact. Tarian explained:

> You may have heard about the "good enough therapist"? When I teach, I often talk about the importance of being "bad enough." People have no interest in someone who's perfect. They will enjoy meeting another human, where there is something genuine.

With accumulated experience, the therapists noted that their self-criticism decreased and they gained insights into factors affecting therapy that were out of their control, such as aspects of their clients' motivation and the course of the illness. In one therapy, Tyme expressed the idea of mutual responsibility to a client and got the client to partake more fully: "You shouldn't believe that you can do everything [in therapy] yourself." Terri started to accept not being able to save some clients. Instead of feeling guilt after a client's suicide, Terri said to herself, "'God, this is sad! Probably no one could have done anything. Just accept it.'" Then with more experience, several informants mentioned how they developed strategies to handle self-doubt and fears. One such strategy was learning to note more subtle improvements in their clients. Terri reported that even though one client had a new psychotic episode after therapy, it "Wasn't *as* fateful. The patient didn't radiate as much fear through the eyes compared to the last time." Another strategy was to see that setbacks, though difficult, provided material to use in therapy. Taffy pointed out:

> [If the patient] experiences psychosis, they can open up and get more in contact with themselves. Something breaks, which isn't good, but it might not be disastrous either. You notice: Here's an opportunity to work and reach a new level.

As their experience increased, the therapists also described being less frightened by the clients' symptoms and coping with them better. Tiger reported: "It's simply about not becoming scared and being able to calm the patient down: 'Don't get lost, this will work out!' This approach has evolved over the years—I have worked for a long time." Furthermore, knowing how to properly use confusing episodes in therapy to help clients seemed to be linked to experience. A few therapists mentioned listening to the clients' main message, rather than to individual words. Trapper told how a client communicated a need for help:

> With patients with psychosis, you instead listen to the message of what is said. You trust that you hear what is important. If someone tells you "I saw my helpers in the corner of my eye...," we don't focus on "who are your helpers really?"

Sometimes, a client noticed that the therapist had developed and commented on that. Tai told about a meeting with a former client in which the client said, "'You've matured—you used to speak *to* me, now you speak *with* me.'" Tai believed this was due to a more relaxed relationship with clients, an abandonment of the constant striving for a neutrality that does not really exist.

An interpretation here is that in the beginning of their careers, therapists commonly seemed to have unrealistic expectations of therapy, which created unwanted effects for both them and their clients. With more experience, the therapists adjusted their expectations and were able to appreciate small changes. Gradually, they also developed ways to cope with doubts and fears and strategies to handle odd occurrences in therapy, enabling them to treat their clients effectively. A crucial step in this process was reconciling themselves to the fact that most clients would not fully recover.

Challenging and Satisfying Work

Conducting therapy for psychosis was described as demanding. Therapists mentioned recovery strategies such as allowing time for breaks, limiting the number of clients they accepted, and planning regular supervision. Because of the demanding relational work, several therapists underlined the need for recuperation between sessions. Trapper explained: "It takes a long time to recover. [It's] almost like riding a roller coaster: you get shaken up physically, you're almost dizzy, nauseous, feeling surreal. You try to gather yourself after the session." Different methods of recuperation were mentioned by the therapists. Terri reported:

> I take long vacations. In our work it is inevitable that you carry the burden and lives of others. You must take a rest from that. As a therapist, you are your own tool or instrument, so you need to be extra careful.

Some needed to be alone at home on weekends to rally. Tevin said, "relationship exhaustion is an occupational hazard." Tevin also reported becoming less social in private life: "Inviting socialization? When I get home, I don't want that: "Let me be!' I wasn't like that before, and I'm not like that late in my vacations. It's work that make me like that." Several informants took breaks after certain sessions to recover. Tarian planned recurrent outdoor jogging outings after sessions in a challenging therapy, and Tory disclosed, "When the patient leaves, I feel nauseous. I must leave the room. Preferably, [I go] outdoors, I drink a cup of tea and collect myself." To achieve a sustainable workload, Tiger expressed that it was important to recognize when personal limits had been reached: "I can't have too many difficult patients, my mind won't suffice. When I have X [number of] patients, I know I can't take any more!"

Supervision as an important component in recuperation was highlighted by several therapists, and metaphors such as immunization or detoxification were used to illustrate the benefits. Tai, for example, asserted, "Supervision can be great. You can regard it as a kind of immunization: you might get ill, but you won't get *as* ill, it blows over quicker. You can fall far, but you'll get up faster." Tarian saw supervision as crucial for survival as a therapist:

> Psychosis is sort of contagious. It's really intense. It's not without its dangers, this line of work. You need to be detoxified. Supervision—sharing these experiences with another human—is essential for survival, to find time and space for reflection. Otherwise, I believe that you have no choice but to protect yourself by shutting down, becoming inattentive. And then you're useless.

Despite all the challenges, many of the therapists said they felt fascinated by the phenomena of psychosis and were fulfilled by being with the clients in their struggles and when they took important steps towards health. On those occasions, the therapy was rewarding. Tory expressed it as follows:

> It's maybe a little bit taboo, but this suffering is indeed my area of interest. Everyone I meet is incredibly interesting and exciting! I want people to understand the magic in getting access to that inner world. I get goosebumps. Four years have passed, and a patient can finally talk about what's going on inside them! It's really awesome. This is my driving force, to reach that point. That's where we were heading all along!

Similarly, Terri described assisting the clients in finding their identities: "[I] feel like a spiritual midwife: they find their own identity. To be part of that is huge, it really is."

Our interpretation is that professionalism involved becoming more resilient, coping with experiences of inadequacy and being able to attend to one's own needs. Therapists needed to be self-compassionate, allowing time in between challenging clients and using weekends and vacations wisely to recuperate. The benefits of supervision were stressed. One reason for enduring the struggles related to working with psychosis is that therapists felt self-actualized and enjoy being invited into the fascinating inner worlds of their clients.

Discussion

This study explored what it is like to conduct psychotherapy with clients suffering from psychosis and how psychotic experiences played a role in therapy. More specifically, it focused on understanding what psychotherapists believe characterizes such therapy, especially in terms of challenges and helpful strategies and, finally, experiences of professional development in the context of therapy for psychosis were explored. This section will consider our findings in the light of the literature, offer a critical evaluation and indicate professional insights.

Therapists' Views of the Characteristics of Therapy for Psychosis

Therapists' experiences of conducting therapy for psychosis were primarily presented in the "Laying the Groundwork for Therapy" section. The therapists often struggled with periods of meagre contact, with clients appearing aloof or unaffected by the, sometimes painful, content of a session; establishing meaningful and emotional contact with their clients could be a struggle. The clients' negative symptoms (e.g., emotional flatness), defensiveness or suspiciousness towards the therapists could be obstacles to the sharing of experiences or emotions or contribute to an unwillingness to relate to the therapists. One therapist even characterized psychosis as a self-sufficient psychological state in which individuals withdraw into a self-explanatory fantasy world where all things external, such as human relationships, become superfluous or threatening. The issue of engagement in therapy in relation to psychosis was discussed in a study by Thompson and colleagues (Thompson et al., 2021), where the authors found that readiness to engage in therapy was higher in clients who had fewer symptoms (both positive and negative). These results indicate that symptoms of psychosis may indeed impair the ability to relate to other people, which is in line with the experiences of the therapists we interviewed.

In contrast, some sessions were described as emotional roller coasters. Despite several years of experience working with psychosis, therapists sometimes felt taken aback by their own strong reactions, which mirrored their clients', during such sessions. Shedding some light on this finding, previous research has found that people in close relationships (such as the therapeutic relationship) commonly co-experience strong emotions (Lang et al., 1993; Wild et al., 2003). In this context, it is interesting to consider the well-documented phenomena that experiencing psychotic symptoms can be highly frightening (Reed, 2008). The fact that this fear also affects the therapists is therefore not surprising and may even be an inseparable part of therapy for psychosis. Also, when the contents of the clients' psychosis (e.g., paranoia, voices or hallucinations) are inaccessible to the therapists, it may be difficult for therapists to understand what causes their co-experienced emotional reactions, making it perhaps more difficult to down-regulate them by, for example, using reasoning. Even if these shared strong emotions and psychosis experiences were often described as frightening or at least unpleasant, they were also often perceived as moments of deeper contact. In a similar sense, "letting go" to co-experience the clients' inner worlds was seen as a useful first step in order to reach a deeper understanding through reflection on these experiences at a later stage.

Specific Experiences of Challenges in Therapy

Therapists' experiences of challenges in therapy for psychosis were discussed in the "Constrained Therapists" section. One such challenge, also briefly touched upon above, was when therapists experienced that clients did not respond to their efforts to establish contact. When clients came across as emotionally unengaged, feelings of frustration or fatigue were experienced, and the therapists had difficulty concentrating on the clients' words. Handling episodes of emotional detachment in therapy was discussed to some degree in Di Rocco and Ravit (2015), where one participating therapist described how the clients' unemotional recounting of a painful trauma made it difficult to recall its details in the following sessions. These observations align with memory research, where emotional events have been found to be more easily remembered (see Tyng, et al., 2017). Emotional stimuli induce a "pop-out" effect that captures attention and increases the likelihood that the event will be coded into long-term memory. Thus, a lack of emotional co-experiencing by therapists may lead to disrupted memory encoding. Thus, teaching strategies to regulate attention and emotional awareness could be valuable for therapists in training.

Furthermore, the therapists in the present study reported feeling confused, eerily unreal or even paranoid about their clients during sessions, gradually getting sucked into the clients' psychotic worlds. In effect, and in line with Saayman's (2018) interview study, on therapists' experiences of negative countertransference in clinical work with psychosis, their professionality and critical thinking was often hard to access under such sessions. However, the setting aside of critical thinking could also be voluntary when deliberately going along with the delusional experience. This momentary "letting go" sometimes felt uncomfortable, even if it was deliberate and it enabled the therapists to listen empathically and build a foundation for shared understanding. Previous research has also shown that both persecutory beliefs about the therapist and the therapists' voice being part of the clients' voice hearing occur in therapy and can indeed pose a real threat and cause aggressive behavior, especially with first-episode psychosis (Lawlor et al., 2015; Reed, 2008; Payne et al., 2006). Indeed, some of the therapists we interviewed described reactions of fear to paranoiac clients.

Helpful Strategies in Therapy

Therapists reported helpful moments in therapy in the "Laying the Groundwork for Therapy" and "A Fragile Framework for Therapy" sections. They stressed the importance of being persistent, making numerous attempts to establish contact, as well as being flexible and creative. Strategies such as finding common interests (e.g., discussing music) or bonding through unrelated activities (e.g., table tennis) were described. Also, when clients had psychotic experiences in the presence of the therapist, these could offer opportunities for deeper contact through active and non-confrontational listening. Other strategies for overcoming barriers to contact have been discussed in earlier research; for instance, Thompson et al. (2021) mentioned how a collaborative attitude, including explaining the form and content of the treatment in order to mitigate misconceptions, could lead to more positive attitudes towards therapy. Thus, trust is built through transparency. In the present study, the therapists reported striving for openness by, for example, explaining and giving their genuine reasons for cancelling a session or being subdued during a session. This approach mitigated the risk of causing harm by sparking the clients' imaginations. Furthermore, the therapists commonly emphasized the importance of expressing genuine emotions—not only for establishing trust, but to model the successful communication and handling of difficult emotions. The clients were often highly sensitive towards their therapists' actions and reactions, and by openly addressing these, misunderstandings could be avoided. The importance of therapists' congruence between emotions and communication in therapy has already been noted in the 1960s by the humanistic psychotherapist Carl Rogers (Rogers, 1966), and is likely to be important in all psychotherapy. Judging from the therapists' accounts in the present study, however, authenticity may be particularly crucial for clients with psychosis.

In the third category, the therapists also stressed that it was essential to tread lightly during sessions due to the perceived fragility of their clients. To handle this fragility, the therapists emphasized the strategy of supporting, which meant meeting the emotional needs of their clients and making them feel safe in the relationship. Supporting also involved more concrete aspects, such as the therapists' comforting gaze and tone of voice, as well as establishing stable routines for therapy. Different forms of support seemed to enable the clients to begin speaking more freely about their psychotic experiences. Communicating carefully in order not to create ruptures in the therapeutic alliance was often mentioned. This involved the strategy of agreeing to disagree, also described by the therapists in research by Lawlor et al. (2015) and Saayman (2018). Helpful moments occurred when clients were able to readily acknowledge that their experiences were different from the therapists' and other people's experiences (even if the experience was not labeled as psychotic). On a similar note, McGowan et al. (2005) found that both therapists and clients viewed the ability to hold two explanations simultaneously as important for the progress of therapy, which they referred to as "twin track explanations."

Even though psychosis, by definition, involves the breakdown of a shared reality, some aspects of the psychotic content were seen as informative for understanding the clients' issues. Deciphering the clients' underlying messa*g*e rather than taking what was said at face value was mentioned as helpful, where the psychotic experience was again understood to have some bearings on clients' reality. This emphatic approach has been highlighted in previous research as well (Di Rocco & Ravit, 2015; Laufer, 2010; Siirala & Ketonen, 1983), where not merely dismissing symptoms as neurological ills enabled the therapists to respond to the content of the clients' psychosis as "enlightening events" (Laufer et al., 2010; Saayman, 2018). This may require that the therapists drop their expert role temporarily to explore their clients' psychotic experiences (Brabban et al., 2017). Being open to multiple explanations also enables therapists to model skills and attitudes for their clients, such as openness, collaboration and, importantly, flexibility in thinking (Brabban et al., 2017).

In the therapists' experience, sharing authentic thoughts required careful consideration of what to share and when. Carefully weighing and timing their words was seen as crucial, although this carefulness could conflict with being authentic, which entails being honest about what are non-shared perceptions. Balancing this dilemma may be more challenging in therapy for psychosis than therapy for most other

conditions not entailing strong idiosyncratic beliefs. Attempts to challenge were described as "walking on a minefield." In the same vein, one therapist in the study by Lawlor et al. (2015) used the metaphor "walking on eggshells" to describe how confrontation could feel. That said, some clients were also described in this study as having periods when they were more robust, when the content of the psychosis could be discussed more openly and critically. This highlights the need to carefully monitor the current wellbeing of the client to pace the therapy. The need to put the relationship at risk could arise even in well-established therapies when a shift from a supporting approach to a more challenging and reality-oriented approach was called for in order for therapy to progress. However, in the long run, being overly reassuring could also risk the relationship, because on some level, clients know that the therapists experience reality differently, and therefore might feel overprotected.

Professional Development: The Need to Recuperate

How experiences with psychosis clients played a role in the therapists' development was discussed in the "Professional Doubts, Growth and Recuperation" section. Therapeutic work was often described as taxing. The therapists experienced self-doubt and a sense of failure when progress was slow, and they had difficulty relying on traditional therapeutic techniques. Miscommunications and confrontation that lead to relational breakdowns gave rise to therapists feeling guilty, clumsy, or lonely. Feelings of inadequacy were also evoked by a lack of concentration or the inability to remember what clients had said.

The therapists also reported how in the process of professional growth they had to shift focus from expecting full recovery and actual symptom reduction to accepting increased function, well-being, self-understanding, and the ability to manage life and relationships. Tempering their expectations to "cure" psychosis was central. Learning to appreciate small steps forward as well as using setbacks or psychotic episodes creatively to further their understanding of the client came with experience for several therapists. Unrealistic expectations for therapeutic outcomes were even pointed to as a risk factor, making the therapy more likely to be experienced as a failure by both client and therapist. Research shows that the relationship between therapy expectations and outcome is even more complex, however, as more optimistic expectations for outcomes (in both therapist and client) are in many cases associated with better results in psychotherapy, although this relation is partly mediated by the quality of the therapeutic alliance (see Bowkers, 2021 for a review). Taken together, the discussed results point to the importance of thoughtfully balancing optimism regarding clinical outcomes against the risks of unrealistic expectations.

An important finding in the present research was the emotional stress experienced by therapists engaged in psychosis work. Feeling disconnected from reality or paranoid could sometimes last for several days, and the clients' emotional flatness could give rise to feelings in therapists of being tired or worn out. Several therapists described how they often brought home such feelings into their private lives. To continue to function as therapists, planning for breaks or walks between sessions and using weekends and vacations wisely for recuperation were important for handling such feelings. Another strategy was being mindful about workload, such as the number of clients that were booked. The most commonly mentioned coping strategy was continuous therapy supervision.

Critical Evaluation

With only 10 informants, the sample needed to be regarded as a single group. Consequently, we could not investigate or detect different patterns of experiences, for example comparing those with more or less experience or those using different therapeutic approaches. Also, only two different therapeutic approaches (Psychodynamic and Cognitive Behavior Therapy) were included. Future research is needed to see whether similar patterns of responses would be repeated, preferably including a wider scope of therapy approaches. Nevertheless, given the scarcity of previous research, it is interesting that several themes in this study also appeared in previous research.

Even though the present results shed some light on what makes psychosis therapy work, we believe that future research should further explore therapeutic techniques and strategies that are experienced as useful for promoting therapeutic progress. More specifically, further research is needed on how to successfully challenge psychotic beliefs. When and why do the therapists use certain strategies? How do they perceive limitations of different techniques?

We believe that interview characteristics may have influenced the patterns of answers. For example, the fact that the interviewers were students at the final year of their psychologist training may have made informants more generous in the sharing of both difficulties and challenges. A sense of partaking in the development of their profession and to provide inspiration to future colleagues and therapists-to-be may have acted as motivation and made the interviews rich. In the same vein, most of the therapists provided advice-like accounts. The fact that the interviewers were students may also have led to more detailed descriptions of how it was for the informants as beginners (e.g., Tarian on how beginner

therapists think they "can save the world", p. 15), and on how they retrospectively looked upon their professional growth (Tarians remark on the "bad enough therapist", p. 15), as well as stirring generosity in sharing tips and strategies (Tiger on recognizing personal limits: "not have too many difficult patients" p. 16) and how to promote professional progress and resilience. Two such examples are Terri who found a way to talk about delusions, namely as "*their* experience" (p. 12) and Tai who did not believe in a "neutral and clinical" therapist approach (p. 7).

We also believe that the interview actors not knowing each other might have helped create a fairly natural situation for the experienced therapists to tell psychologist students about their work experiences. Being open with their shortcomings might have been more difficult if they had been acquainted.

That the therapists are both experienced in and probably comfortable with establishing contact with new people, as this is common both in supervision and in clinical work (e.g., when meeting new clients), increases the depth achieved and the ethical integrity of our data collection.

Finally, we believe that it is an advantage that five independent interpreters (with different experience) performed the analysis. This diversity may contribute to increased credibility and rigour of the results.

Practical Implications and Conclusions

The present research on therapists' experiences with psychosis have the potential to help new therapists in the field to understand and therefore prepare themselves for what is to come. It also may validate the feelings of doubts and fear that are common, even among experienced therapists.

The recommendations for therapy for psychosis drawn from the therapists' experiences include the need for *flexibility*—for example by adjusting the content of the sessions depending on the quality of contact. Early on, the therapists may need to be persistent and more active than their clients to establish contact and may choose to engage in common activities. Flexibility may also involve following along in the clients' psychotic world—not confronting or questioning but listening and tolerating strong emotions without fully knowing what causes them.

Further strategies for establishing contact include being emotionally genuine, sharing emotions as a way of modeling emotional functioning, and being transparent regarding personal matters that may influence patients. The strategy of supporting involves being warm and empathetic but also providing structure in therapy in order to offer a secure enough foundation for the relationship to grow. Later, to retain trust and confidence, a careful weighing of words and consideration of timing are recommended, especially when discussing the clients' psychotic experiences.

Other strategies involve refraining from challenging psychotic symptoms or moving forward in a sensitive way by agreeing to disagree. In service of the therapy, however, some challenging of the psychotic symptoms must occur and therefore a balancing act must be performed at some point in which therapists alternate between being solely supporting and challenging symptoms so as to not cease striving for authenticity.

Some of these strategies could be addressed in training and tutoring and seem crucial to enable effective therapy for psychosis. The therapists' strategies for resilience to preserve their well-being may be used as further recommendations for support. It seems essential, for example, to use supervision regularly to mitigate the risk of fatigue. Also, due to the emotionally taxing work, it is crucial to allow time to recuperate by taking short breaks during the day and not overbooking appointments, as well as allotting time during weekends and vacations.

The therapists in this study experienced their work as both highly challenging and deeply rewarding. They described—somewhat paradoxically—feelings of inadequacy in the face of psychosis on the one hand due to the slow progress, but on the other hand, appreciation for being invited into their clients' inner worlds, which resulted in deep learning about both the clients and themselves. Professional work satisfaction was often mentioned and was illustrated by the fact that most therapists had worked with this patient group for one or more decades.

References

Bowker, H. (2021). *Understanding the influence of outcome expectations on attendance, dropout and clinical outcomes in psychotherapy* [Doctoral dissertation, University of Sheffield].

Brabban, A., Byrne, R., Longden, E., & Morrison, A. P. (2017). The importance of human relationships, ethics and recovery-orientated values in the delivery of CBT for people with psychosis. *Psychosis, 9*(2), 157-166.

Cuijpers, P., Reijnders, M., & Huibers, M. J. (2019). The role of common factors in psychotherapy outcomes. *Annual Review of Clinical Psychology, 15*, 207-231.

Di Rocco, V., & Ravit, M. (2015). With psychosis in mind: The reverberations of the psychotic encounter. *Psychoanalytic Psychotherapy*, *29*, 57-69. doi:10.1080/02668734.2015.1004189

Garety, P., Fowler, D., Kuipers, E., Freeman, D., Dunn, G., Bebbington, P., Hadley, C., & Jones, S. (1997). London–East Anglia randomised controlled trial of cognitive–behavioural therapy for psychosis: II: Predictors of outcome. *British Journal of Psychiatry, 171*, 420-426.

Huhn, M., Tardy, M., Spinelli, L. M., Kissling, W., Förstl, H., & Pitschel-Walz, G. (2014). Efficacy of pharmacotherapy and psychotherapy for adult psychiatric disorders: A systematic overview of meta-analyses. *JAMA Psychiatry, 71*, 706-715. doi:10.1001/jamapsychiatry.

Lang, P.J., Greenwald, M. K., Bradley, M. M., & Hamm, A. O. (1993). Looking at pictures: Affective, facial, visceral, and behavioral reactions. *Psychophysiology, 30*, 261-273.

Laufer, B. (2010). Beyond countertransference: Therapists' experiences in clinical relationships with patients diagnosed with schizophrenia. *Psychosis*, *2*(2), 163-172. doi:10.1080/17522430902736893

Lawlor, C., Hall, K., & Ellett, L. (2015). Paranoia in the therapeutic relationship in cognitive behavioural therapy for psychosis. *Behavioural and Cognitive Psychotherapy*, 43(4), 490-501. doi:10.1017/S1352465814000071

Laws, K. R., Darlington, N., Kondel, T. K., McKenna, P. J., & Jauhar, S. (2018). Cognitive behavioural therapy for schizophrenia-outcomes for functioning, distress and quality of life: A meta-analysis. *BMC psychology, 6*(1), 32.

McGowan, J. F., Lavender, T., & Garety, P. A. (2005). Factors in outcome of cognitive-behavioural therapy for psychosis: Users' and clinicians' views. *Psychology & Psychotherapy: Theory, Research & Practice, 78*(4), 513-529.

McKenna, P. A. (2000). Learning to conduct psychotherapy with psychotically disturbed patients. *Clinical Supervisor*, *19*(1), 205.

Newton-Howes, G., & Wood, R. (2013). Cognitive behavioural therapy and the psychopathology of schizophrenia: Systematic review and meta-analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, *86*(2), 127-138.

National Institute for Clinical Excellence (2009). *Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care.* NICE.

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: *AMEE Guide No. 149, Medical Teacher.* doi: 10.1080/0142159X.2022.2057287

Payne, J., Malla, A., Norman, R., Windell, D., & Brown, N. (2006). Status of first episode psychosis patients presenting for routine care in a defined catchment area. *Canadian Journal of Psychiatry, 51*(1), 42–47.

Reed, S. I. (2008). First-episode psychosis: A literature review. *International Journal of Mental Health Nursing, 17*(2), 85-91.

Rogers, C. (1966). Client-centered therapy. In S. Arieti (Ed.), *American Handbook of Psychiatry* (pp. 183-200). Basic Books.

Saayman, N. (2018). Psychoanalytic psychotherapists' experiences of disturbance in response to working with psychosis, *Psychosis, 10*, 329-339, doi: 10.1080/17522439.2018.1534879

Siirala, M., & Ketonen, O. (1983). *From transfer to transference: Seven essays on the human predicament*. Therapeia Foundation.

Smith, J. A., & Fieldsend, M. (2021). Interpretative phenomenological analysis. In P. M. Camic (Ed.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (2nd ed.) (pp. 147-166). American Psychological Association. https://doi.org/10.1037/0000252-008

Smith, J. A., Flowers, P., & Larkin, M. (2021). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.). Sage.

Steel, C., & Smith, B. (2013). CBT for psychosis: An overview. In C. Steel (Ed.), *CBT for schizophrenia: Evidence based interventions and future directions* (pp. 1-12). Wiley-Blackwell.

Terry, P. (2004). Working with psychosis: Part 2: Encounters with an omnipotent super-ego. *Psychodynamic Practice: Individuals, Groups and Organisations*, *10*(1), 45-49. doi:10.1080/14753630310001656036

Terry, P. (2005). Working with psychosis: Part 3: Struggling to contain madness: Losing and recovering a capacity to think. *Psychodynamic Practice, 11*(1), 29-39. doi:10.1080/14753630400030106

Thompson, E. C., Spirito, A., Saarinen, J. S., & Wolff, J. C. (2021). Psychosis-spectrum experiences linked to specific psychotherapy readiness domains among psychiatrically hospitalized adolescents. *Early Intervention in Psychiatry, 15*, 949-956.

Turner, D. T., van der Gaag, M., Karyotaki, E., & Cuijpers, P. (2014). Psychological interventions for psychosis: A meta-analysis of comparative outcome studies. *American Journal of Psychiatry*, *171*, 523-538. doi:10.1176/appi.ajp.2013.13081159

Tyng, C. M., Amin, H. U., Saad, M. N., & Malik, A. S. (2017). The influences of emotion on learning and memory. *Frontiers in Psychology, 8*, 1454.

Wampold, B. (2015). How important are the common factors in psychotherapy?: An update. *World Psychiatry, 14*, 270–77.

Wild, B., Erb, M., Eyb, M., Bartels, M., & Grodd, W. (2003). Why are smiles contagious? An FMRI study of the interaction

between perception of facial affect and facial movements. *Psychiatry Research: Neuroimaging, 123*, 17-36.

Zala, D., Brabban, A., Stirzaker, A., Kartha, M. R., & McCrone, P. (2019). The Cost-effectiveness of the improving access to psychological therapies (IAPT) programme in severe mental illness: A decision analytical model using routine data. *Community Mental Health Journal, 55*, 873-883.

About the Authors

Associate Professor Jens Knutsson is the Head of the psychotherapist training program at Lund University. He is also a licensed psychologist, psychotherapist, and psychotherapy-supervisor. He works as a researcher and teacher at the Department of Psychology, Lund University, Sweden, and practice at the clinic for youth with bipolar disorder and psychosis at Lund University hospital. He has published widely, both within the fields of psychotherapy and forensic psychology.

Rebecka Jägestedt completed her training as a psychologist at Department of Psychology, Lund University, Sweden at master's level and with a combination of CBT and PDT diploma. She works as a psychologist at the Child and Adolescent Psychiatry in Malmö, Sweden.

Malin Persson completed her training as a psychologist at Department of Psychology, Lund University, Sweden at master's level and with a combination of CBT and PDT diploma. She works as a psychologist at the child and adolescent psychiatry in Stockholm, Sweden, predominantly with the assessment of neuropsychiatric and personality disorders.

Jonas Ramner completed his training as a psychologist at Department of Psychology, Lund University, Sweden at master's level and with a combination of CBT and PDT diploma. He works as a psychologist conducting psychodynamic psychotherapy in a private practice in Malmö.

Associate Professor Eva Hoff is a researcher and teacher in developmental and personality psychology at the Department of Psychology, Lund University, Sweden. She has published widely within research concerning well-being, self, and creativity, including the book *Creativity Psychology: In theory and Practice. Liber.* (2014). Four PhD-students have finished their theses under her supervision