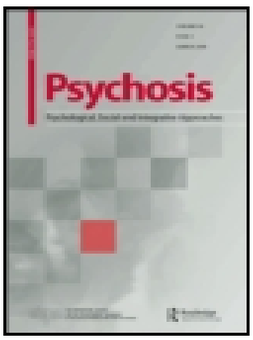

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Identifying psychological resistances to using logic in cognitive-behavioral therapy for psychosis (CBTp) that limit successful outcomes for patients

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ABSTRACT

The small to modest effect sizes of cognitive behavioral therapy for psychosis (CBTp) invite the question, do some treatments not succeed because patients mobilize psychological resistances to treatment that limit outcomes? This paper identifies 10 psychological resistances to CBTp, 7 that undermine the use of logic when examining delusional beliefs, and 3 best considered from a psychodynamic viewpoint. Resistances to progress in CBTp defined in the paper include logic evasion, logic monopolizing, logic blinding, logic partitioning, equivocation, reactive reassertion, feeling-percept fusion, mind-guarding, peripheral preoccupation, and external expectancy. When therapists recognize the operation of these defenses, they may aim to diminish their impact on the treatment. Ways the therapist might address these resistances in psychotherapy are suggested.

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Cognitive behaviour therapy; delusions; hearing voices; integrative approaches; psychodynamic psychotherapy

Much has been written about cognitive behavioral therapy (CBTp) and psychodynamic psychotherapy for psychosis (Arieti, 1974; Beck, Rector, Stolar, & Grant, 2009; Garfield & Steinman, 2015; Garrett, 2017; Karon & Vandenbos, 1981; Kingdon & Turkington, 2005; Lotterman, 2015; Lysaker et al., 2011; Marcus, 2017; Morrison, 2013; Rosenbaum, 2009; Wright, Turkington, Kingdon, & Basco, 2009). Meta-analyses of randomized controlled trials of CBTp find small to modest effect sizes for CBTp (Jauhar et al., 2014; Laws, Darlington, Kondel, McKenna, & Jauhar, 2018; Wykes, Steel, Everitt, & Tarrier, 2008), notably with some efficacy in medication-resistant patients (Rathod, Kingdon, Weiden, & Turkington, 2008). Effect sizes for CBTp are generally lower than effects obtained from other psychosocial interventions for schizophrenia (Kurtz & Mueser, 2008; Kurtz & Richardson, 2012; Wykes, Huddy, Cellard, McGurk & Czobor P, 2011). CBTp's modest effect sizes invite the question – do some treatments not succeed because patients mobilize psychological resistances to CBTp that limit outcomes? We describe ten resistances that may undermine CBTp's effectiveness (see Table 1).

What constitutes resistance in psychotherapy?

Leahy (2001) defines resistance in CBT as " … anything in the patient's behavior, thinking, affective response and interpersonal style that interferes with the ability of that patient to utilize the treatment and to acquire the ability to handle problems outside of therapy and after therapy has been terminated." pg 11. Several patient-related variables such as degree of cognitive

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Table 1. Ten forms of psychological resistance encountered in CBTp.

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

flexibility, insight, coping skills, and level of functioning appear to predict success in CBTp. Metacognitive capacity is important in matching treatment to patient (Lysaker et al., 2011). Other treatment-related factors such as the quality of the therapeutic alliance and engagement, accuracy of formulation, beliefs about therapy, and the duration of treatment also appear to impact outcome from CBTp (Allott et al., 2011; Brabban, Tai, & Turkington, 2009; Dunn et al., 2012; Holding, Gregg, & Haddock, 2016; Jolley et al., 2015; Naeem, Kingdon, & Turkington, 2008; O'Keeffe, Conway, & McGuire, 2017; Perivoliotis et al., 2010; Premkumar et al., 2011; Steel, Tarrier, Stahl, & Wykes, 2012). Knowledge of factors that predict response to CBTp in the selection of appropriate clients and attention to the appropriate treatment process can allow CBTp to be provided in an efficient and cost-effective way. However, in many cases, when patients seemingly appropriate for CBTp are paired with skilled therapists, therapy does not progress in an optimal manner. Forms of psychological resistance are common reactions to highly directive interventions, such as teaching, questioning/information seeking, confronting/challenging, and interpreting/reframing frequently deployed in CBTp (Bischoff &Tracey,1995).

Resistance, viewed as a psychologically motivated, largely unconscious process aimed at avoiding painful truths, is a cornerstone of psychodynamic theory and technique (Freud, 1936). By psychological resistance we do not mean the patient's resistance to an external agenda imposed by outside agents, but rather an internal resistance to thinking and knowing about one's self that emerges from within the patient to avoid dysphoria.

The ten psychological resistances we report were identified in meetings of an in-patient peer-supervision group of psychologists, psychiatrists, and social workers (CA, LC, JDP, KH, VF, AA, JG) led by a psychiatrist trained in both psychoanalysis and CBTp (MG). While most authors were trained in both CBT and psychodynamic approaches, and were open to combining them (Garrett & Turkington, 2011), the predominant paradigm in the group was CBTp. Members took turns presenting treatments that did not seem to be progressing. Before each group discussion, the presenting clinician distributed a brief summary of the patient to be discussed along with a partial transcript of sessions that highlighted issues of concern. This written material was reviewed by all members of the team prior to the team's weekly discussion. One goal of the peer supervision was to identify psychological resistances and other obstacles to progress in treatment. The list of resistances presented in this paper emerged inductively from the discussion of 32 patients in the course of a year of weekly meetings. The first author reviewed the summaries and transcripts of these patients, along with notes made at each discussion, and prepared a preliminary list of

resistances that were then presented in draft to the group, which led to a final list with descriptions of each resistance. We view this paper as a pilot project in clinical theory development that we hope will be of use to clinicians and researchers.

In CBT-based approaches, resistance is generally considered a product of a strained therapeutic alliance or collaborative process (Coutinho, Ribeiro, Hill, & Safran, 2011; Eubanks-Carter, Muran, & Safran, 2010; Safran, Muran, & Eubanks-Carter, 2011; Watson & McMullen, 2005). Such strain may be manifested in the form of confrontation such as when discontent, anger, resentment, or disagreement with the therapist is expressed. It may also be manifested as a withdrawal in the form of emotional detachment from the therapist, the therapy process, and emotions. Attempts to resolve such rupture may include strategies not necessarily specific to CBTp practice: renegotiation of treatment goals, empathizing and validating the patient's feelings, instilling hope, reiterating coping strategies, and practical problem solving. (Eubanks, Burckell, & Goldfried, 2018). Care recipients may hold differing perspectives, expectations, and misconceptions about psychotherapy for psychosis that may impact their level of engagement (Holding et al., 2016). Therefore, patient's beliefs about CBTp as it impacts engagement could be a target for resolving resistance related to the therapy process. Traditional CBTp does not however formally address resistance viewed as a psychologically motivated, largely unconscious process that maintains delusions and maladaptive appraisals of perceptual aberrations.

Marcus (2017) has drawn attention to the existence of "non-psychotic mediating defenses" that resist change in psychotic symptoms. These psychological resistances are preconscious emotional experiences that prevent full access to and consideration of psychotic symptoms. To our knowledge, our report is the first attempt to elaborate a comprehensive description of unconscious psychological resistances that may be encountered in CBTp.

Resistances to the use of logic in CBTp

Some patients attend sessions, participate in discussion, and in keeping with standard CBTp, give cogent summaries of homework, but their treatment does not seem to advance. They go through the motions of CBTp but maintain their core beliefs. CBTp is a multi-faceted treatment approach which emphasizes the importance of the therapeutic alliance (Norcross, 2011) as well as specific techniques, with the aim of reducing stress. The same is true of psychodynamic psychotherapy. CBTp, in addition to fostering a positive therapeutic alliance, encouraging more effective coping skills, and assistance in problem solving, includes a number of techniques in which logical reasoning plays a role, including making inferences by noting the contexts in which a symptom does or does not occur, evidential analysis (rating the likelihood of beliefs, rating the value of evidence), exploring advantages versus disadvantages of belief, informational handouts, inference chaining, and behavioral experiments that use logic to design ways to test beliefs. These techniques are useful with patients who have the meta-cognitive capacity to benefit from their use (Lysaker, 2011). To the extent that logical reasoning plays a role in CBTp, resistances that interfere with bringing logic to bear on symptoms are of clinical concern. The first 7 resistances described below undermine the power of logic in CBTp, while the next 3 slow progress for a variety of reasons best considered from a psychodynamic viewpoint. Patients often employ multi-layered resistances, in many cases motivated by some form of "mind-guarding" as described below, creating a defensive pattern typical for the individual. For example, fear that psychotherapy will erode a vital psychological structure may underlie a patient's vague or noncommittal responses or may prompt the patient to reaffirm a delusion in a reactive, strident manner.

(1) **Logic evasion –** claiming to be an exception to logic

Some patients grant that if other people were to entertain the same delusional ideas they maintain, those people would be delusional ("crazy"). But the patient claims to be an exception to logic; i.e.

logic does not apply to his or her circumstances. For example, a homeless psychotic man who believed he was a descendant of the Egyptian God Horus acknowledged, "You're right. I know it sounds crazy, but it's true. I am Horus." Another man, when made aware that he is not the only person who feels that his mind can be read, responded, "Those poor bastards are really sick! But my situation is real."

When the patient claims to be an exception to logic, instead of raising doubts about a particular delusion, the therapist might address the patient's selective use of logic, saying, "We see you using logic when you think about other people, but you don't seem to believe that logic applies to you. When it comes to the most important issue in your life [the delusion], you seem to throw logic out the window when you might need it the most to figure out what is going on. That seems remarkable to me, but this double standard about logic doesn't seem to bother you. There is something special about [the delusion] that makes you approach it very differently than anything else in your life."

(2) **Logic monopolizing –** claiming to be a master logician

Just as the CBTp therapist hopes to use logic to encourage the patient to evaluate beliefs, the patient may lay down what appears to him or her to be a definitive "logical" argument proving the truth of the delusion. When patients invite therapists to joust in a tournament of syllogisms, there may be no recourse but to meet the patient on the only terms the patient offers – to think more like a lawyer than a clinician. A clever argument mounted by the therapist will rarely, if ever, dissuade the patient, but when the patient claims to be the sole arbiter of logic, the therapist might be advised to address this resistance in therapy.

Here is an example of a therapist working with a patient master logician by trying to fine tune a logical argument. A woman with no history of any relevant medical condition claimed periodically to see a distant "aura," then to "go blank" briefly. She was convinced the "aura" was a signal that God was about to transmit a message, one she couldn't remember because it was transmitted during the blank period. When the therapist asked why she was the only one who saw this "aura," she responded, "You must have faith that the aura is there before you can see it." She returned the next session with an advertisement for margarine that claimed, "Tastes like real butter!" The patient began, "How do you know it tastes like butter? You don't. You must have faith first before you buy it." The therapist replied, "You are telling me you must believe in the margarine before you buy it, like you must believe in the aura before you see it." With a smile, the patient replied, "Exactly!" satisfied she had proven her case. The therapist continued, "I think I follow your argument, but I'm not sure it settles the question for me. I must have faith that the margarine might taste like butter before I buy it, but I don't need faith to see the margarine. In fact, I must see it before I can have the faith to buy it. We are back to your seeing an aura that no one else sees, and your believing you received a message from God that you cannot remember. This is a hard and lonely life."

(3) **Logic blinding –** dissociating logic from its emotional implications

Some patients seem to achieve insight into the meaning of their psychotic symptoms but do not register the emotional significance of their understanding. In a psychological split that goes beyond the familiar defense of intellectualization, an enthusiastic, collaborating self shows up for sessions while the delusional self remains hidden and untouched (Winnicott, 1960). For example, a 26-year-old man, quite dependent on his aging mother, did not consider her failing health a problem. He believed that one of the numerous dramatic videos he posted online would go viral, earning him a movie deal from a media giant. He sent the following insightful email after a session. "I was severely bullied as a child and this shapes how I perceive the world. My mom isn't stopping me from having a life. The reason I don't leave my room is extreme social anxiety. Since I'm scared of the real world, I tell myself the videos I make are going to make me famous and be my ticket to

independence." The therapist asked if he was feeling nervous about his future when he wrote the email or when he thought about it now in session. He paused, then said, "No. Does that mean I don't really mean it when I say I need to take charge of my own life?" He questioned whether he "really" meant his email in the same emotionally detached tone in which he had sent it. The therapist suggested, and the patient agreed, that they should regard moments of anxiety as a sign that he "really meant" what he was saying about his future, and therefore a likely indication of progress. This intervention was intended reconnect logic to its emotional implications by inviting the presence of appropriate anxiety.

(4) **Logic partitioning –** conceding that logic suggests that some beliefs are likely untrue, without changing core delusions or recognizing the psychological processes that generate new delusional beliefs

Persons suffering psychosis may cite a single, life-changing experience as proof that a delusion is true or offer countless examples of separate events that the patient believes add up to proof, as in successive ideas of reference that seem to point inexorably to a delusional conclusion. In the case of a singular event, akin to plea bargaining, the patient may concede that numerous beliefs peripheral to a core delusion may be false, but the foundation of the delusional evidentiary chain remains unchanged. For example, a woman with an olfactory delusion conceded in CBTp that there might be other reasons people coughed in public than her having a bad smell, but she remained convinced that many years prior, she had heard a stranger on the street say, "That woman smells!" The treatment foundered until patient and therapist found a way to examine this memory.

Patients, particularly those with frequent ideas of reference, may concede that in one instance an event might be mere coincidence. But they say, in effect, "We can examine separate events and come up with alternative explanations, but even if some of these are coincidence, there are too many coincidences for this to be chance. There is definitely something going on behind the scenes." The delusion is reborn in each successive experience of an idea of reference that is taken to be new evidence that confirms the patient's belief. A strength of CBTp is its focus on cognitive processes rather than isolated beliefs. For example, a man acknowledged that it made no sense that television commentators were speaking directly to him, but the next day he readily believed that the way strangers on the bus looked at him betrayed their personal knowledge of his affairs. The therapist had best interest the patient in the question, "Are you dealing with 100 examples of corroborating evidence, or are you making the same biased interpretation 100 times?"

(5) **Equivocation** – offering vague, nonspecific, noncommittal responses that provide little traction for logical thinking

To the extent that logic plays a role in CBTp, vague answers prevent logic from gaining cognitive traction. If the therapist encourages possible alternative explanations, the patient may answer "maybe" or "possibly" or "perhaps." Vague, noncommittal responses may indicate that the patient is going through the motions of therapy but is not emotionally engaged. If the therapist says, "The voices seem to know only what you know, so perhaps they are not as powerful as you think?" the patient may respond, "That could be," or "I see your point." Instead of thinking in sufficient detail to reach a considered logical conclusion, the patient turns the session into a string of hypotheticals.

A man believed he occasionally emitted a sulfurous odor. When the therapist asked for examples of people noticing this, he provided only one, a time where his college roommate commented on his smell. The therapist said she considered it odd, since he thought his odor was so overpowering, that only once had someone noted it. She then wondered if there might be an alternative explanation of his roommate's comment. At first, he reflexively said no. Then he said "maybe" the roommate was noticing something other than the sulfur smell. Then, with logic

closing in on the delusion, he retreated to total equivocation, saying, "I don't really remember what happened with my roommate." When a patient is equivocal, therapists may be reluctant to press a point. While therapists shouldn't badger patients, they can gently hold them to the work. "When you say 'maybe' do you mean that the other explanations we've been discussing might very well be true, or do you mean it could possibly be true, or that anything is possible so there isn't much point in discussing alternatives?"

(6) **Reactive reassertion** – expressing a reactive, strident reassertion of t delusion when the patient senses a logical challenge

Even when the therapy is tactfully well-paced, when logic presses the patient to face what they do not want to face and feel what they do not want to feel, patients may raise their voices and shout the therapist down in a peremptory manner, to brush aside what the therapist is saying or about to say. Angry and exasperated, a patient may say, "You don't get it! You don't believe me. My situation is real!" Such reactions are the equivalent of a growl, meant to drive the therapist back, to dominate logic with emotion. Readers may recall the old legal saying, "When the facts are on your side, pound the facts. When the law is on your side, pound the law. When neither is on your side, pound the table." Rather than retreat, the therapist might frame the strident retort as a happening to investigate. "It seems we were starting to think through some implications of your belief when suddenly you felt very stirred up. You raised your voice. Something got triggered that made it impossible to continue talking. I wonder what happened exactly?" The therapist might interpret, "A moment comes when we are discussing alternative beliefs when you get angry, I think because you feel frightened. It's scary to re-think what you have believed for a long time. When you are scared you can only feel safe in a world of people who believe exactly as you do."

(7) **Feeling-percept fusion** – ignoring considerations of logic because of a strong "feeling" that the delusion is true, despite logical evidence to the contrary

Some patients concede that logic suggests the delusion is false, but they nevertheless *feel* it to be true. The patient's feeling of truth carries the day. In psychosis, boundaries between thoughts, feelings, perceptions, and memories break down, giving rise to mental states that fuse cognition, feeling, perception, and memory into novel hybrid forms of experience that rarely occur in ordinary mental life (Garrett, 2017). Marcus (2017) describes these states as "thing-presentations" of mental events that merge reality experience and emotional experience. Jaspers (1963) called this experience "delusional perception." In feeling-percept fusion the delusional meaning of an experience emerges not as a cognitive distortion per se, but rather in an idiosyncratic meaning that is inextricably embedded in the perception of an event. Said another way, in the A-B-C cognitive model, where an activating event A results in a belief B that has an emotional or behavioral consequence C, the A and B are fused in a hybrid subjective state that blends perception, feeling, and cognition. If we define "emotional reasoning" as a cognitive distortion that leads people to believe, "If I feel something to be true, it must be true. There must be a basis in fact for my feeling." then feeling-percept fusion differs from "emotional reasoning" in that it involves a subjective blending of thoughts, feelings, and perceptions into a hybrid form of experience which is characteristic of psychotic states, but a rare occurrence in non-psychotic persons who exhibit "emotional reasoning."

When a psychotic person says, "I knew by the way the stranger looked at me that he was an FBI agent" or "I could tell by the sound of my sister's voice that she was working with the aliens" or "I could tell by the way my stomach was rumbling that a computer chip had been planted in my body" feeling-percept fusion is likely involved. Working with emotional reasoning and feeling-percept fusion have a similar aim – to invite the patient to see that feeling is not fact. But while a non-psychotic person may acknowledge that their *feeling* that a catastrophe is in the offing is an

over-reaction not grounded in fact, psychotic persons may experience their perception of an event as self-evidently true, absent any self-reflection. Because people are inclined to equate what they perceive (what they see and hear) with reality, when perception condenses with emotion, cognition, and memory, the "perceived" quality of an experience infuses it with the feeling of a perceived reality. Add to this that emotions have a here-and-now insistence that feels subjectively real, hybrid experiences in psychosis are felt to be objectively real. Whereas a clinician working with emotional reasoning might explore cognitions about feelings, when exploring feeling-percept fusion, it is important to examine the patient's actual perceptual experience in detail. This can be done by inviting the patient to describe what precisely did he or she perceive that led to his or her belief. In the case of feeling-percept fusion, the patient will be unable to characterize what precisely about a look, or a sound, or a body sensation logically implied their conclusion.

A patient reported that he and his social worker had seen crows in trees on the hospital grounds, which he saw as an indication that he was an evil person. The therapist asked, since the social worker had also seen the crows, why would the patient be evil and not her? The patient replied, "I can't explain it. I just feel it." When the therapist asked, what if roles were reversed, and the therapist and social worker were to tell him they had seen crows and concluded they were evil people, he chuckled and said, "OK, I see your point. I'd tell you that didn't make sense." When the therapist tried to extend this insight to examine his conviction that a neighbor planned to kill him, he insisted, "No, that's a fact. I can tell by the way he looks at me. I can just feel it!"

Consider another example. A psychotic man feared going out because he believed his neighbor's dog possessed x-ray vision and could see his puny body underneath his clothes. He believed the dog was mocking him with its eyes. He knew this to be true (he had a feeling of truth) because his experience of the glance of the dog was a hybrid merger of his perception of the dog's eyes with his own self-hatred, born of traumatic life experiences, about which he felt much shame. The therapist might ask, "What precisely was different about the way the dog looked at its owner versus looking at you? Oh, I see, you cannot really describe the difference between an owner look and an X-ray look. Anyone near you would see the dog look at you, but you read a meaning into your perception of the dog's eyes that no one else sees. It is more a feeling you have about an ordinary event than a fact you can demonstrate to others."

(8) **Mind-guarding –** the psychotherapy threatens to erode a vital psychological structure upon which the patient's identity, vitality, self-esteem, or emotional regulation depends

Some psychotic symptoms play such an essential role in the patient's mental life that the person defends the symptom against logic at any cost. In such cases it is essential that the therapist have a psychodynamic understanding of the meaning of the symptom and a familiarity with psychodynamic technique (Klein, 1946). In a broad sense, the concept of mind-guarding invites the inclusion of psychodynamic thinking about psychosis into CBTp. For example, it may be difficult to see that persecutory delusions, while causing great suffering, may also be the patient's main reservoir of hope. Patients who believe their lives have failed because of a persecutor comfort themselves with a counterbalancing fantasy; i.e. if the persecutor were to be removed, the patient would flourish, unimpeded, with certain success. Rather than accept that a belief is delusional, which would invite the stigmatizing label of mental illness, patients may defend their delusional identities as if their emotional lives depended upon it.

Clinicians may well assume that grandiose delusions are vital psychological structures that support self-esteem in patients who claim to be exalted figures like Jesus, the President, a genius, a millionaire, or a person in possession of special powers. The grandiose delusion serves as a counterpoint to what would otherwise be devastating low self-esteem. Over time, supported by a positive therapeutic alliance, the therapist can, when opportunity affords, ask the question gently, in so many words, "Which would you prefer? The illusory promises of a grandiose daydream that never seems to materialize, or self-esteem grounded in the real world, in your ability to give

and receive love?" Self-esteem building exercises may be a necessary prelude to the patient questioning a grandiose delusion. The therapist must help the patient grieve the loss of their daydream, in part by offering the reality of the therapeutic relationship in its stead. Mind-guarding may also serve as an underlying motivation for the other forms of resistance and defense listed in Table 1.

Consider two examples of mind-guarding. A woman believed that "one-to-two-inch homunculi" had invaded her body, causing her physical pain. CBTp helped her challenge ideas of reference but left beliefs about the homunculi unchanged. To exorcise these entities, the patient had engaged several gurus and clinicians trained in ancient healing arts. She once had a guru to whom she felt so connected that she believed she could communicate with him psychically after he died. But disagreements arose in their posthumous talks. She sought counsel from another guru to whom she complained about her dead mentor. Influenced by the second man, she came to believe that the deceased guru had sent the homunculi to punish her for disloyalty.

The following backstory helped the therapist understand why the homunculi belief resisted change. The sadistic homunculi were reminiscent of boarding school personnel who had physically abused the patient. When her first guru died, she had felt abandoned. Rather than feel angry or grieve her loss, she denied his absence by continuing to communicate with him psychically. Her anger surfaced only after she had connected with a new guru, but her guilt over condemning the deceased guru persisted. Understood psychodynamically, the persecutory entities she believed had been sent by the deceased guru were a projection of her own voice-of-conscience, sent to punish her for betraying her first mentor. Like people from the past, who were both loved and hated in their time, the entities were emissaries of her once-beloved guru, too precious to dissolve in the solvent of logic.

CBTp can be combined with psychodynamic technique to build on the strengths of both methods (Garrett & Turkington, 2011). CBTp is a superior technique for using logic to help patients consider the literal maladaptive falsity of delusional beliefs when measured against consensual reality. Psychodynamic technique is a superior method for showing patients the figurative truth of delusions. Consider an example in which a delusion was a figurative representation of a traumatic memory that, because of its historical truth, was resistant to logic. A psychotic man reared as a devout member of a strict religious sect expected and dreaded being arrested because of his interest in internet child pornography. CBTp successfully questioned multiple delusions, including his belief that patients on the ward were FBI shills planted to catch him. However, his belief that a short voicemail he had received the day before his hospitalization was an "accidental" recording of two police officers discussing him was impervious to challenge. Equally resistant was a ten-year delusion that his upstairs neighbors, installed by the FBI to surveil him, came in late at night, made noise, and talked about him. In support of his belief he insisted, "I heard it! I have a weird-sounding last name. I wouldn't mistake my name! I could hear them banging around up there!"

These delusions did not yield to CBTp but did respond to psychodynamic technique. Earlier in treatment, he had described the painful year he turned twelve-years-old. His beloved mother died, and his father took up with, and eventually married, a woman he felt had turned his father into an alcoholic and brought pornography into the house. Neglected, he tried to be "the best boy in the world," desperate to help the family regain its equilibrium. The therapist asked him to try to remember what it was like at age twelve as he lay in bed feeling anguished and alone. As he responded, he had an "Aha!" moment. He described lying in bed, hearing his drunk father and stepmother coming home from a bar late at night, "banging around upstairs." He suddenly stopped short, tears welling up in his eyes. He looked shocked and said, "Did you hear what I just said?" He had connected the FBI neighbors banging around upstairs with his parents doing the same. His discovery of the figurative significance of the noise led him to wonder if he had really heard what he thought he heard, and to question his belief that he was being monitored.

(9) **Peripheral preoccupation** – the patient is preoccupied with an underlying emotional concern that is not embedded in a psychotic symptom per se and thus has not been recognized as a central focus of therapy

Some patients are preoccupied with a powerful underlying emotional concern that is not directly expressed in a psychotic symptom, in which case this concern rather than a psychotic symptom per se is a paramount apprehension. Such patients are emotionally half-present in sessions, while most of their energy is devoted to suppressing states of anxiety, terror, grief, rage, and other painful affects related to their preoccupations. Unless the therapist can find ways to address these affects, they remain a hidden elephant-in-the-room that drains energy from the treatment. For example, a man said that he repeatedly called the police from the hospital phone "because they must come immediately." His underlying fear was that he would not be able to reach his brother, upon whom he greatly relied; i.e. that his brother would not come immediately when he needed him.

A woman who was admitted with loose associations, voices, and suicidal ideation. After her positive psychotic symptoms abated, she continued to avoid social contact, fearing she would "say the wrong thing." Her family had told her she said strange things prior to admission. No one in the hospital said she was behaving strangely. Despite the therapist's use of standard CBTp techniques to show that what she feared was not occurring, she remained frightened and socially isolated. Peer group members wondered if the problem was the past rather than the present. Possibly the CBTp work was inadvertently traumatizing her by reminding her of periods of cognitive disorganization in the past when she had said "inappropriate things," psychotic episodes that she preferred to "seal over."

The therapist focused away from examining her belief that she was being "inappropriate" toward what appeared to be her terror that she was one loose association away from madness. The therapist "normalized" loose associations by telling her that everyone had occasional "slips" and "inappropriate" thoughts. Seemingly odd associations occur along a continuum, from a "healthy mind" at one end to the cognitive disorganization of psychosis at the other. She noted that many jokes, puns, and crossword puzzles depend on novel associations that people might consider "inappropriate" if taken out of context, reassuring the patient that there is an appreciable distance between "wacky" thoughts of an ordinary sort and the loose associations she had experienced in the past. She reminded the patient that her medication appeared to keep her in a mentally healthy zone. The patient began to relax. "Maybe I've just been really self-conscious? It's just me thinking that I'll say something weird even though I'm not really doing that anymore."

(10) **External expectancy** – relying on external agents and contingencies as instruments of change rather than one's own hard work in therapy

Some patients rely on anticipated contingencies or agents outside themselves instead of trusting in their own capacity to recover. They may imagine that some event will finally placate the persecutors, who will then relent, or that some defender will rise up on their behalf and defeat the persecutor, as in one woman's belief that a powerful man who was in love with her would claim her as his bride once he no longer needed to keep the relationship secret "for security reasons." Or patients may imagine that some miracle in the offing will bring success, fame, and fortune. One earnest young man believed that a group of older men, "the Elders," read his mind with a machine, chastising him with messages embedded in traffic noise whenever he had a "disrespectful" thought. He divided his life into week-long cycles of hope. When disappointed week after week that the surveillance continued, he reset his expectations by reassuring himself, "This is the week they are going to let me off and give me a ten-million-dollar book deal."

When patients rely on external contingencies, they set themselves the task of enduring their suffering while waiting for their deliverance. The therapist is relegated to the role of a kindly

companion who simply waits with the patient. Patients resist logic when logic suggests that they have lost significant periods of their adult lives to mental illness, and that they must look within to find the strength to recover. Medication alone cannot salve the grief that accompanies this realization. When patients bet on a contingency, they can't fully invest in psychotherapy. The therapist might say, "It seems you are hopeful that all you really need to do is hold on a while longer, and this whole situation will change without our needing to do much. How painful it would be to think otherwise and believe in yourself. I am here if you decide to rely more on yourself and take a different path."

In summary, a variety of psychological resistances may undermine the therapist's efforts to bring logic to bear on psychotic symptoms in CBTp. Therapists need to recognize when such resistances are operating and address them in psychotherapy to diminish their impact. By taking the initial step of naming and describing these resistances, we hope to encourage research to refine an understanding of the resistances named in the paper, to discover others, to chart their frequency, to describe their underlying mechanisms, and to develop improved techniques that mitigate their influence, allowing logic to exert its full therapeutic power. It may prove to be the case that at this time advances in the psychotherapy for psychosis may come as much from the integration of already existent cognitive-behavioral and psychodynamic knowledge and techniques as from CBTp and psychodynamic clinicians inventing new interventions.

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