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Alone in a Crowded Mind: When Psychosis Masks Loneliness

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This article explores the relationship between loneliness and psychosis, with respect to how psychosis constitutes a longing for connection and reality, how harrowing loneliness both precedes and follows psychosis, even triggering it in some individuals. It also examines some strategies individuals with psychosis use to cope with loneliness and how psychosis and its treatment further isolate a person, increasing loneliness. Finally, it discusses how therapists who treat psychosis experience a particular kind of loneliness in the countertransference. Case material is presented.

Keywords: loneliness, psychoanalysis, psychosis

The loneliest moment in someone's life is when they are watching their whole world fall apart, and all they can do is stare blankly.
—F. Scott Fitzgerald

The charcoal drawing of the whitened face of the great French mime, Marcel Marceau, greeted clients at my office entrance. One analysand, Amy, very fond of Marceau, avoided eye contact with me, though never failing to nod hello to the expressively sad face of the mime, who held out his white gloved hand in supplication. They were two of a kind, she told me; they understood each other implicitly. Following the exchange with Marcel Marceau, she sat down and began speaking. Before leaving, she would bid the mime goodbye.

One day, appearing troubled, Amy paused before the drawing, and flatly announced, "Marcel Marceau is dead!" "Oh," I said surprised and feeling sad. I knew Marcel Marceau was old, but I hadn't read the paper that day to hear of his demise.

After beginning the session, I noticed something unusual taking place. Amy repeatedly shifted her head from side to side—as if watching an imaginary tennis match. I asked her what was going on. "You don't see him?" she asked incredulously. "No," I replied and asked if she would tell me what *she* saw.

"There's a homeless man in your office," she said, still in disbelief that I was unable to see him. "He's mute," she added. I quietly noted the connection between her hallucination and the silent art of the supposedly deceased mime. Could she describe him to me? I wondered aloud. "He's ragged, thin, hungry." I asked her why she had been moving her head from side to side. She told me that the mute was scurrying back and forth, running to hide in the corner and then scampering very close to me. She demonstrated how the mute reached his hand out to me, nearly touching my leg—the gesture identical to the one in the drawing of Marceau.

Later, I discovered that Marcel Marceau was alive and well. Amy had killed him off and created a mute homeless man to take his place. For the next three months, Amy and I shared our sessions with the mute.

Amy, a middle-aged woman, lived alone. Her sessions with me were the only human interaction in her day. She told me that she battled hallucinated rats on the way to see me five days a week, demonstrating her courage to overcome psychotic obstacles and engage in challenging psychological work. She had difficulty knowing her emotions and telling me what she felt. Her creation of the homeless mute served multiple functions. He helped us both understand her loneliness and fear, expressing her hunger for human contact and nourishment better than her words ever could. The mute assured her of company. It stood in for the mute unconscious; and it was a hallucinated figure of an-other. It was the ghost of Marcel Marceau, something dead in her yet whose spirit might be brought back to life. Finally, the mute tested my capacity to care for her and keep alive a desperate, neglected, and emotionally famished human being.

Loneliness, a universal human experience, wrought by a significant gap between one's actual social relations and one's needed social relations, is, for many, the most painful state (Cacioppo & Patrick, 2008). Loneliness is different from solitude, the condition of being alone; loneliness is the subjective, emotional and cognitive evaluation of one's social position. One can feel lonely, unseen and unknown, while surrounded with people, and one can feel fulfilled and complete when physically alone (Knafo, 2012). Although solitude can inspire creativity (Knafo, 2013), the impact of loneliness is largely negative: compromised immune system, lower quality of lifestyle, anger, depression, early death, even madness and violence (Cacioppo & Patrick, 2008).

Patients diagnosed with psychosis are up to six times more likely to report having felt lonely in their life (Kimhy et al., 2006; Meltzer et al., 2013), with the majority (80%) reporting to having felt lonely in the past 12 months (Badcock et al., 2015): A staggering 74.75% of people with delusional disorders and 93.8% of those with depressive psychosis suffer from loneliness. These numbers are taken from a study of 1642 participants. Rates are significantly higher than those in the general population—around 35% (Badcock et al., 2015). These statistics bring to mind many questions. Are some people psychotic because they are lonely, or is it their psychosis that isolates them? Clearly, psychosis and

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loneliness are intricately intertwined. The disposition/personal history of persons suffering this kind of disorder naturally predisposes them to not feeling understood, known, or seen. At the same time, they are already isolated, and such isolation can bring about and deepen psychosis.

In this paper, I briefly explore the special nature of psychotic loneliness as an exile from reality. I discuss the general relationship between loneliness and psychosis and how the former plays off the latter, even triggering psychosis in some individuals. I also examine some strategies individuals with psychosis use to cope with loneliness. In particular, I look closely at paranoid delusions and hallucinations as defensive coping mechanisms against loneliness. I further address loneliness in psychotics who primarily exhibit negative symptoms. I also argue that the hospital and medication treatment of psychosis further isolate a person, increasing loneliness and stigma. Finally, I discuss how therapists who treat psychosis experience a particular kind of loneliness in the countertransference.

Several threads will run through this paper and derive from over three decades of work with psychosis. First, the conception that the psychotic's world is singular, solipsistic, and difficult to share (except in therapy, and even then, very indirectly), hence it is a lonely world. Psychosis is a communication from the depth of one's radical aloneness, unconsciously fashioned to hold all the clues to recovery. Second, despite the many writings on psychosis that describe it as an a-social retreat from reality and relationships, I maintain that there exists a hidden desire for relatedness in the psychotic state. The psychotic state itself, as manifested in its symptoms, contains a deep cry for connection and understanding. Third, too much aloneness is already a form of madness, because we need others to reinforce and uphold what we call reality. *Human reality is inherently relational*, based on implicit agreement among individuals. The innate relatedness of the mind demands the other as an anchor for one's reality. We learn reality at our caretaker's knee and through her nonverbal and verbal communications. We come to know ourselves and the world through each other. The psychotic break is a rupture of the link between oneself and others that sustains a vision of reality that we call normal. Thus, madness creates a state of isolation and disconnection that often triggers psychosis, and psychosis further guarantees isolation. It is a negative feedback loop.

Psychoanalytic Literature on Loneliness and Psychosis

There is a dearth of psychoanalytic literature on loneliness, and even less on its relationship with psychosis. In "The Neuro-Psychoses of Defense" (Freud, 1894/1962), Freud described the case of a woman suffering unrequited love. Unable to tolerate her love object's rejection and her feelings of abandonment and loneliness, she enters a hallucinatory state, in which her lover arrives and speaks to her. In this "dream state" she lives happily for two months. Though Freud used this case to illuminate the concept of repudiation or foreclosure (*Verwerfung*), it can also be read as a psychotic defense against loneliness. Later, in his analysis of Schreber's (Freud, 1911/1962) memoir, Freud explained how Schreber's psychotic symptoms were his way of trying to reconnect with the object world. Freud understood early on that world catastrophe, a common experience among psychotic individuals, like Schreber, clearly expresses profound loneliness, for it is like a death. One is always alone in one's catastrophes. But what is truly catastrophic in psychosis is the nature of that loneliness—*loneliness for reality itself,* particularly for the safety of reality in its coherence, meaning, and connection.

Erich Fromm wrote in 1941 that "To feel completely alone and isolated leads to mental disintegration just as physical starvation leads to death" (Fromm, 1941, p. 19). Harry Stack Sullivan (1953), known for his emphasis on interpersonal relations, believed that loneliness is the most painful of human experiences, more painful even than anxiety. He pointed out the different forms of contact humans require at multiple points of development: Infants need contact, tenderness, protective care; children need adult participation in activities; juveniles need peers and acceptance; and preadolescents need intimate exchange, friendship, love. Failure to receive these forms of human exchange lead to loneliness, derailment of development and personality. This is why Sullivan encouraged active involvement between psychotic patients and aides at Sheppard-Pratt Hospital where he worked, becoming the origin of milieu therapy.

Frieda Reichmann (1959) was one of the first to explicitly note a connection between loneliness and psychosis. In her final paper, published posthumously, she wrote: "I offer the suggestion that the experiences in adults usually described as a loss of reality or a sense of world catastrophe can also be understood as expressions of profound loneliness" (p. 5). She believed that a deficit of attention and acceptance from significant adults during infancy and childhood results in later loneliness and yearning for interpersonal closeness that can take the form of psychosis. Based on my own experience with patients diagnosed with psychosis, I believe such an environmental deficit weakens reality formation, increasing the probability of psychosis setting in on the heels of a later catastrophe. As reality itself is installed via embodiment—the lived repetition of actions, thoughts, words, relations, and meaning from infancy onward—it will be installed more firmly in some than others, depending on interaction of constitutional and environmental factors. A supportive environment establishes a stronger sense of reality—one's own and the world's. Whenever the self slips away, the world slips away with it.

Melanie Klein (1963) understood loneliness in terms of paranoid and depressive anxieties, derivatives of the infant's psychotic anxieties. She believed that everyone possesses these anxieties, but they are more pronounced in depressives and schizophrenics. According to Klein, schizophrenics feels little or no sense of belonging to another person or group. They have split-off parts of the self that are projected into others. This fragmentation ensures that "one is not in full possession of one's self . . . one does not fully belong to oneself or, therefore, to anybody else. The lost parts, too, are felt to be lonely" (p. 302). Unable to internalize the good mother, to secure a stable foundation for social connection, the schizophrenic "is left alone . . . with his misery" (p. 303). With psychic fragmentation, it becomes difficult to distinguish between good and bad objects and between internal and external reality. Paranoid distrust emerges, which results in social withdrawal and more profound loneliness. The predisposition to psychosis, however slight, may bring about behavior that increases isolation and may crack the psychic fault line, leading to full blown psychosis, which gives rise to even further isolation. It becomes a vicious cycle. This is no surprise, because we now know that nonpsychotics often develop "reactive prison psychosis" during prolonged

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solitary confinement (Grassian, 2006). Grassian writes that "These persons" display "florid psychotic delirium, characterized by severe confusional, paranoid, and hallucinatory features," and "intense agitation and paranoia" (p. 328).

With Klein we again see how important reality formation is in *belonging* and feeling whole. And, as I said before, the loneliness that emerges from the break is not the ordinary, even terrible, loneliness that people suffer; it is the hellish horrific psychotic kind in which one is exiled from self and world—from reality itself.

Even though Winnicott (1965) viewed the "capacity to be alone" to be a developmental milestone, he also defined psychosis as an "environmental deficiency disease" (pp. 135–136). Harold Searles (1965), too, alleged that "schizophrenics" repress both dependency needs and feelings of loneliness.[1] Undoing the repression of the former, he found, reveals the chilling presence of the latter: "the fleetingness of life, the impossibility . . . to overcome our innate separateness from each other" (p. 397). Searles wrote:

> Probably there is no greater threat to the schizophrenic than the repressed knowledge of his aloneness, the realization that he, who yearns so strongly for oneness with another person, not only has the same inevitable aloneness as every human being, but in addition is even more completely cut off from his fellow human beings by reason of his isolation within his schizophrenic illness. (p. 123)

In sum, the loneliness in psychosis refers to: (a) the loneliness of being isolated in chaos and hungering for reality, (b) the loneliness of being isolated from others as a result, (c) the "natural" loneliness one carried prior to the break as a result of "environmental deficiency," (d) the loneliness of feeling exiled from one's better, stronger, saner, more whole self. All four causes of loneliness can be understood by the fact that humans need others to anchor themselves in reality—a human sociocultural reality—which then anchors them in physical reality.

Loneliness and the Onset of Psychosis

I remember treating a middle-aged man, Mr. L, married for 25 years before his wife abandoned him. Because they worked together, his means of support and social network also quickly evaporated. As he scrambled to survive his losses, he confessed that his "harrowing, bone-aching loneliness" was driving him insane. He said he had to continually check to make sure his wallet and keys were where he had left them because he was possessed by the absurd idea that they might disappear. Several times during his sleepless nights he would go to the window to make sure his car was out in front because he was certain someone would steal it. Every stranger seemed threatening to him and he heard strange noises every night, unsure whether they were coming from within himself or the world around him.

Eventually, on the verge of suicide and about to hang himself from a hook he'd fastened to the ceiling, a spider building a web nearby "spoke" to him, convincing him not to go through with it. Mr. L had no previous psychiatric history nor did his parents or grandparents. Because Mr. L was a writer, I encouraged him to journal as one way of coping with his suffering. Here is one of his telling entries:

> When I roll up in front of the shanty where I now live, the driveway is empty and the streets eerily quiet. No one waits for me to return. No one calls to ask when I will be coming home. I will climb a set of foreign stairs and enter a strange apartment. It will be empty. There will be no dinner, no wife, no daughter, no one making small talk about the day. There will be no friends with whom I can raise a glass or share a laugh. Roxanne will *not* sit next to me on the couch. She will *not* hold me in her arms anymore. She will *never* again look at me and smile just because I am the one she is looking at. We will offer each other *no* further comfort.
>
> When the sun finally sets on this day that takes so long to end, I will still be alone, facing an even longer darkness. The black night will become a desert and my desire to sleep a narrow tunnel, dimly illuminated by the flashing phosphorescence of unbearable thoughts. Choking on my solitude, I will crawl my way toward another bleak and lonely dawn. I will lie awake in my bed most of the night, astonished at how much pain it is possible to feel. When, craving oblivion, I finally doze for a few minutes, even sleep will be torturous, periodically jerking me awake in terror, and I will reach for her, and she will *not* be there. Each time I awake with a gasp to find that, yes, it's true, *her absence is real,* I will face this unbelievable reality and whimper in the darkness like a mortally injured wolf. What will keep me company during this time is the very thing that will make my solitude especially unbearable: the shame and humiliation of a loss I do not comprehend.

Not surprisingly, initial psychotic episodes usually occur in late adolescence through early adulthood when young people first experience separation and loss of loved ones, finding themselves alone and on their own for the first time in their lives. Remember, too, it is during this time that the young person's *reality* is undergoing major revisions. They are coming into their own aloneness, *and* they are alone. A 2018 study conducted in The Netherlands (el Bouhaddani, et al., 2018) found that social exclusion during adolescence is closely related to psychotic experiences. Identities are not yet fully formed, and external pressures to perform in school, work, or new social groups can feel like too much to bear. The loss of people and function leaves the person feeling alone and lonely—susceptible to regression, dissociation, and fragmentation. When one is constitutionally vulnerable and/or has a traumatic history, these possibilities become more likely. Cacioppo and Patrick (2008), prominent loneliness researchers, found "people misuse their powers of cognition in their attempts to self-regulate the pain of feeling like an outsider" (p. 77). In other words, people distort reality and delude themselves to assuage the angst of isolation. This misuse can take extreme forms in the cases of those vulnerable and wounded.

Treatment of Psychosis and Loneliness

That psychosis results in further loneliness should be patently obvious. Persons diagnosed with psychosis are hospitalized and medicated, placed in seclusion rooms, separated from their loved ones and families. The condition isolates them; the institution isolates them; and the medication often puts them in further exile

[1] I place the term schizophrenia in quotes because it is a highly disputed term that does not refer to one diagnosis and that carries a great deal of stigma. Yet, when quoting some authors, I use the term because they have. The diagnostic label is being contested in the United States and has already been changed in Japan and South Korea. One might argue the same can be said about the term psychosis. Yet, psychosis does not have the degree of negative associations that schizophrenia has.

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from themselves. Many have told me that antipsychotic medication makes them feel like zombies, dead inside.

Furthermore, the stigma of psychosis and hospitalization is internalized (Świtaj, Grygiel, Anczewska, & Wciórka, 2014). The patient feels shame and further withdraws. Though the hospital may be needed for one who suffers psychosis, it also erodes one's individuality, robbing autonomy and, because patients are frequently treated like children, encouraging regression (Knafo & Selzer, 2017). As they become part of "the system," "chronic patients" often develop additional symptoms to allay loneliness. Research (Chrostek et al., 2016) shows that the more one undergoes inpatient hospitalizations, the more loneliness one suffers. On the other hand, some patients stop taking their medication or find another reason to be rehospitalized because the hospital is the only place where they find people who talk to them and take an interest in them. The hospital reality, as awful as it might be, at least offers some semblance of safety and coherence, a reality for the psychotically exiled.

Psychotic Symptoms as a Way of Coping With Loneliness

In this section, I try to demonstrate how psychotic symptoms both express self-world exile and attempt to cope with it. Bereft of social relationships, one can be maddened by loneliness. Psychotic symptoms are a way of coping with the agony of loneliness. Amy created a mute homeless man to convey her sense of loneliness to me and also to provide herself with some companionship. Searles (1965) described a woman who hallucinated bugs and turned them into people to have some company. In a paper I wrote with Selzer (Knafo & Selzer, 2015), we describe a woman who hallucinated eight children as a desperate tactic to care for her abandoned child self while providing herself with a family.

It is often said that psychotic individuals are alone because they retreat from reality and live in their inner world. Their need for others is reduced because their inner world is what counts. That so many psychotic individuals complain about feeling lonely disputes this argument. Like Mentzos (1993), who argued that psychotic symptoms possess object seeking functions—in particular, in their attempt to balance the conflict between object needs and self-safety—I have begun to consider psychotic symptoms as ways of coping with loneliness in their attempts to establish ties to the object world. This understanding informs my interventions and treatment in general. Paranoia, for example, seems to be a natural consequence of extended isolation. Cacioppo and Patrick (2008) claim that because we are social beings who require support and resources from each other, aloneness can feel threatening: "Feelings of isolation and perceptions of threat reinforce each other to promote a higher and more persistent level of wariness" (p. 31). That sense of threat and wariness can evolve into full-blown paranoia. *If no one is with me, everyone must be against me.*

I treated Mr. R, a paranoid man who had developed an intricate delusional system. He was convinced that he was being targeted as a serial killer. Signs everywhere pointed to this accusation: TV, radio, even strangers in the grocery store. His mother had been a highly anxious parent, never permitting R. to leave home alone; someone was always watching him. This anxiety literally followed him into adulthood and fed the obsession that others maintained constant interest in his whereabout and activities. If so many people were watching him, then he must be up to no good. Despite its draconian cast, his mind recreated a world that mimicked his childhood, in that he was never alone. Lee (2006) wrote that a delusion is a narrative, an "encrypted blueprint of an earlier relational trauma" (p. 44). In this case, that description fit precisely: R's hovering and obsessed mother was duplicated in a crowd of imaginary snoopers convinced he was a serial killer.

Sullivan (1956) believed that paranoia emerged from a need for intimacy coupled with the conviction that one is incapable and undeserving of that intimacy. He wrote in the paranoid's voice: "I want to be close to this person for a feeling of warmth which I need because I'm lonely; but if I move toward him, he will regard me as inferior and unworthy and will deny me this warmth because he won't warm so inferior a person" (p. 160). Likewise, Mr. C explained to me how paranoia and schizophrenia functioned in partnership for him. Whereas the schizophrenia cut him off from the world, paranoia kept him distortedly attached to it. The paranoia kept people at an optimal distance: "If I let people get too close, I fear they will find out I am really a nobody and will abandon me, which is my worst nightmare. But if I keep them too much at a distance, I lose them and am still abandoned." (Knafo, 2016) Mr. C nicely illustrates the compromise between remaining somewhat anchored via relationship but not so much as to be overwhelmed by it.

In some cases, severe obsessive–compulsive disorder can also be understood as a form of paranoia. Patients who fear being contaminated or contaminating others maintain constant negative internal dialogue with the figures of other people—a sad antidote to loneliness. Obsessed with being contaminated by others and of contaminating them, Mr. Z spent most of his time alone, yet his obsessions and compulsions tied him to his internal objects.

Auchincloss and Weiss (1992) considered paranoid delusions as desperate fantasies—magically connecting their bearer to others, thereby undoing object inconstancy and perceived indifference of the object world. Simply put, we feel connected to others if we imagine they possess some of the same thoughts we do, or, at the very least, that they are thinking of us. One patient said, "If people don't get inside each other's heads, how do they relate to one another?" (Auchincloss & Weiss, 1992, p. 1014). The person exhibiting paranoia is split between total indifference and complete relatedness—needing connectedness and therefore projecting delusions onto object relations. Projection functions not merely to externalize unwanted wishes but to keep the other close, even merged (Schafer, 1968), albeit as part of the delusional system. Fairbairn's (1952) suggestion that a bad object is better than no object is relevant here. To this I add that a bad reality is better than nearly none at all. Truly in the delusions of psychotic minds, we find fully exposed the furious psychic power at work in the creation of human reality that is masked by the shared reality of common folk. As brain damage illuminates features of the neurotypical brain through comparison, so too does psychosis shed light on "being normal." As one patient put it, "Sanity is not about being some way. It's not about being normal. It is about holding your own in the struggle not to go mad."

Understanding the object needs of paranoia can guide the analyst's interventions by focusing on the paranoid person's adaptive solutions to the conflict over object seeking needs. One can point out to such patients that they are not only trying to get rid of something; they are trying to *get* something—object connection—

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through indirect means. Untethered to reality, these magical fantasies, if left alone, ultimately backfire, leaving the paranoid person vulnerable to invasion and exploitation or, worse, delusions that the world is coming to an end, which really means that the person's object world is ending. One patient told me, "It's lonely because others cannot even imagine the pain of feeling I caused the end of the world!"

Psychotic symptoms, as substitutes for object relations, are further evident in visual and auditory hallucinations. Not all psychotics hear voices, but those who do usually hear more than one. And not all such voices are negatively experienced, nor do their bearers necessarily wish to rid themselves of such strange company. Narimanidze's (2015) qualitative study on the relational aspect of hearing voices, revealed that many of her participants preferred to keep their voices. This seems surprising since much of the literature on auditory hallucinations connects them to overwhelming, negative, or frightening content (Birchwood, Meaden, Trower, Gilbert, & Plaistow, 2000); even violence and suicide attempts are considered responses to auditory hallucinations (Falloon & Talbot, 1981).

Yet there are people who hear voices that do not disrupt their lives, nor lead to acts of violence (Romme & Escher, 1989). Eigen (1986) aptly noted:

> In hallucinations, the object-world comes back in flagrantly distorted ways, but it does return . . . [the] hallucinatory object-world can tell the story of past wounds and wishes. In them may be read the remnants of a broken history, and at the same time, they represent partial, at times total, fulfillment of the subject's deepest longings. Wounded wishes find a home in hallucinations. (p. 47)

Eighty percent of participants in a study (Nayani & David, 1996) of 100 individuals diagnosed with serious mental illness reported that being alone exacerbated their voices.

It is important to note that a significant number of Narimanidze's (2015) subjects dated the onset of their voices to a particularly desolate time in their lives. They described going through phases of isolation and loneliness, or feeling the need to escape harsh realities, just prior to the onset of auditory hallucinations. Some voices became attached to imaginary companions. One participant said, "I started having imaginary friends because . . . until nine-years-old, I wasn't very sociable . . . I realized from a young age that I had an ability to create something to drown out whatever dysfunction was going on around me" (p. 65).

Another participant located the beginning of his voices at age seven: "I'm usually the one by myself most of the time . . . I hear these voices in my head, when I was a kid, I thought it was normal" (Narimanidze, p. 65). Another participant said his voices were due to "being alone too much, pushing myself away from other people, not being in contact with friends, family" (p. 65). Another questioned if his voices responded to a lack: "I don't really have that many adults to talk to . . . I work with children . . ., but I don't know if that's why I have conversations in my head" (p. 66).

All participants reported an intimate relationship with their voices. "I feel like they know what I've been through," (Narimanidze, p. 45) said one without a trace of irony! Some engaged with their voices to cheer themselves up, seeking them out as companions during long stretches of being alone, for example, while at work or on the road. Another heard a voice that sounded like his deceased mother, including "conversations we used to have just before her death . . . I feel like it probably gives her some closure that I'm still her son and that I still listen to her, there for her, still supportive" (p. 64).

From keeping one company to providing refuge from a hostile, fragmented reality, hearing voices can for some provide a kind of self-care that they are unable to obtain otherwise. If antipsychotic medication costs the psychotic person his or her "social' life, no wonder so many stop taking their meds. As one participant poignantly noted, ". . . if the voices would stop, I would always kinda be alone . . . like something was missing. . . . sometimes when I haven't heard my grandmother in weeks or whatever, I feel a little funny . . . like I haven't had anybody to talk to . . . I tend to be like . . . What's going on? Maybe the medication is working too well" (p. 92).

Clearly, voice-hearing is not always a positive or comforting experience. Yet, opposed to the medical model, which treats the phenomenon with drugs, the Hearing Voices Movement is a peer-led organization that helps voice hearers live comfortably with their voices (Hearing Voices Network, n.d.). Indeed, research conducted by Romme and Escher (1989, 1993) and Craig et al. (2018) indicates that engaging with one's voices seems to ameliorate the distress experienced by voice-hearers. Interestingly, some psychotic individuals are now being successfully treated by interacting with avatars created from their own hallucinations (Craig et al., 2018).

Most of Narimanidze's (2015) participants kept their voices private for fear of being ostracized or deemed incompetent and thus forbidden to care for children or perform at work. This secrecy exacerbates the isolation that may have precipitated the onset of the voices in the first place.

Even in the case of hearing friendly voices, the person with psychosis is still on the inside looking out, suffering a special kind of isolation, what one of my patients calls the "loneliness of being crazy." Until now, I have been discussing the connection between positive symptoms of psychosis and loneliness. When someone experiences the negative symptoms of psychosis—that produce blunted affect, anhedonia, social withdrawal, poverty of speech and thought, and low attention and motivation—loneliness and its effects can be even more acutely felt. The following case of a young Japanese man illustrates this point.

Hikikomori: Loneliness and Negative Symptoms

Hisoka's mother was quick to tell me that she believed his problems stemmed from his having been adopted at nearly two years of age. He was 19 and extremely reclusive when we met. After sitting silently for many minutes during our first session, Hisoka—extremely thin, stiff, and affectless—told me that he had "no goals, no future, no motivation." He never left his house except to come to his therapy sessions, and, when home, he hardly left his room. He was a true *Hikikomori,* a term referring to young Japanese recluses who fail to conform and live in acute social withdrawal that can last for many years (Zielenziger, 2006).

Alone and lonely, disconnected from the world, Hisoka's enormous eyes latched onto mine and didn't let go, communicating the possibility of connection. He stared at me without blinking, leaving me clueless as to what he might be thinking or feeling. We both felt uncomfortable.

"I'm nowhere," he finally said to explain what brought him to see me. Sleeping 12 hr a day while staying up all night, he felt "empty and helpless." His social withdrawal began in high school and increased to the point of clinical depression. After being hospitalized twice for suicidal risk, his isolation became complete. He needed to be homeschooled to obtain his high school diploma. I asked him about his relationship to his family, to which he responded with one word: "detached."

Hisoka and I stared at each other, session after session; he occasionally answered my questions with a word or two. Exasperated with this routine, one day I asked him if he remembered his dreams. Surprisingly, he replied that he dreamt daily. I was thrilled with the opening. He recounted the dream he had had the previous night in which he was lost and not able to find his way home. His sister was in the dream, but he was sure to clarify that she was not *really* his sister. After he told me the dream, he adamantly insisted that he did not believe dreams had meaning. I did not argue with him but simply pointed out that in his dream he was looking for a home (perhaps therapy) because he was with a family who was not really his (referring to his adoption).

Hisoka's dream, as well as his waking life, reveal that his loneliness was of a very special kind. He was lonely not only for the object world, but, also, for reality itself. He was searching for a home—a physical home as well as a feeling of home within himself. Psychosis has often been described as a waking nightmare—the psychotic alone in an idiosyncratic world that is no longer a world. This "world" is like being lost at sea, not safe for a moment, where one is in constant danger of drowning. Edward Podvoll (2003) has written about "islands of sanity" that exist in even the most psychotic among us. Linking those islands—those moments of coherence and those brief contacts with what still feels connected to a shared reality—is the key to restoring the "land mass" of sanity. This is what I tried to do with Hisoka.

Hisoka said no one had ever "got him," and seemed surprised when I said that I would like to be the first. Always reluctant to share, one day he began by talking about animals. He liked dogs, he said, because they are interactive—another sign that he sought connection. We wondered together whether each of us was a dog or cat person. He concluded somewhat sadly that we were both cat people. I added that perhaps he wished I were more like a dog. He nodded silently. I said it seemed much easier for him to speak about animals than humans, to which he replied: "Dogs don't ask me personal questions."

Hisoka seemed not to care much about me until he happened to see me with my son one day. With some urgency, he asked me, "Who's that kid?" immediately answering his own question with, "It's not your kid. Perhaps it's a neighbor's child. Perhaps you molested him. Perhaps he's not a child at all but an adult with a disease." These violent (even psychotic) fantasies indicated that I *was* becoming increasingly important to him. Hisoka reluctantly accepted the fact that I had a child though he projected a lot of himself onto him ("maybe you switched babies at birth") and sometimes asked me about him. He knew I was looking for a cat for my son, and one day he entered my office with a large box filled with kittens born in his backyard. He wanted to give me a kitten for my son. I didn't take an animal, but we spent the hour watching the kittens, noting the ones that were active and energetic and especially those that were quiet, reclusive, and inactive. Weeks later, he told me he had put the kittens up for adoption, making sure they got good homes.

Though Hisoka was clearly getting closer to me, he did not seem to know it. He shared a "vampire dream" to which he associated, "You have to feed on people to survive." Yet he still denied his own dependency. When I returned from a 3-week summer vacation and asked him how it went for him, he said, "Nothing . . . Sorry." After a while, he said, "I either felt nothing or I am not aware that I felt anything." I pointed out that there could be a world of difference between those two states. Soon afterward, he said he thought I wouldn't care if he stopped coming to therapy because I had many other patients. He admitted that he felt I was more important to him than he to me because he had only one psychologist while I had many patients. He confessed that he didn't want to have to think of other people's feelings. For the first time, we spoke of how he could use our relationship to become more comfortable relating to others. Accepting this, he began asking me questions about relationships. "What does it mean to be attached to someone?" he asked. "Is attachment to one person the same as to another?" Hisoka began weighing the pros and cons of attachment and solitude. I empathized with how difficult it was for him to move out of his isolated space.

Hisoka began to think more psychologically too, admitting that one could be influenced by unconscious forces. Once he said, "When a dog has a bad experience with a garden hose, it remembers the emotion but not the actual event. And it reacts every time it's exposed to a garden hose." Then he asked if it would make me feel bad to get rid of a dog I adopted—a clear transference projection of me as his biological mother. We traced this to his feelings about being adopted—gotten rid of. It took us two years to be able to explore the topic of his adoption, mirroring the two years he lived before he was adopted in the United States. I raised the concept of reconstruction and that piqued his curiosity. Could we piece together his early life even though he remembered nothing? He was skeptical but willing to give it a try.

We each did our homework. I researched adoptions from his native country and he brought in early photos and adoption documents given to his parents. We closely examined the photos and observed a plump, well-cared-for infant. We read the documents that told us he had been with his birth mother for approximately a year and a half. We pronounced his original name out loud. Apparently, the father left the mother and she didn't want to, or could not, be a single mother and thus put him up for adoption. "Maybe she was arrested and went to jail?" he proposed. I said, "You turn her into a criminal because you feel she behaved criminally toward you." He then lived with a foster mother to whom he became attached until arriving in the United States, when, for the second time, he was put up for adoption. We spoke about his fortune at having had a long early attachment with his third mother who clearly wanted him. We also discussed the misfortune of having had two maternal attachments and one paternal attachment brutally severed. We spoke of how difficult it might be to open himself up to becoming attached again after that. Although he criticized our reconstruction for not being an exact science, he seemed to accept what we came up with as a "reasonable narrative" of his early life.

In truth, what more could we expect? The losses he experienced occurred so early in his life that they could not be processed as something he remembered or symbolized as such. They were

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radical losses that shaped him at the most primary level, disrupting the process of secure attachment and the sense of being loved and wanted. His losses imbued him with a pall of lifelessness and purposelessness that had left him adrift in a lonely and meaningless world. When he first came to me, he could not even realize the barest sense of his place in a longstanding and loving family. He lived in exile from his very own life. Reconstruction was the best we could do.

One day Hisoka asked me a most important question: Is there a critical time in the life of a person for some important thing to take place and, if it does not, could it occur with effectiveness later on? We related his question to the attachment rupture in his early childhood. Is it possible such a catastrophe can be repaired? Soon he compared his situation to Helen Keller's life, mentioning that she was taught to communicate despite having lived as an isolate due to being blind and deaf. I asked whether he was questioning whether I could teach him the language of emotions, as Ann Sullivan had taught Helen Keller the language of expression. He was intrigued, and I brought him Helen Keller's autobiography in the next session. He read it overnight but was disappointed because he had "wanted more about the miracle of transformation."

Nonetheless, after this discussion, Hisoka asked me if he could move his chair closer to mine. He did and instantly had psychotic associations to cannibalism, revealing how terrifying his dependency needs were. "What would you do for someone you love?" he both questioned and answered, "Hold your breath till you faint? Not blink? Not eat them up!" I saw how frightened he became at being close to me, so I added that I had forgotten to tell him that he could move his seat back as well, which he did with visible relief. Later, he asked me, "How do you separate yourself from your patients? I couldn't do that." He began to say that his need for people, though still slight, was increasing. "After a week of solitude, I get bored." His foray into social life began with online video games that demanded personal interaction and communication.

After 10 years of work, Hisoka has come a long way. He is obtaining his undergraduate degree; he is working at his second job; and he even moved out of his parents' home to live on his own. He paid for his new home from his own savings. He is more animated, smiles and laughs, hangs out with his brother, plays basketball, and eats dinner with his family. Most importantly, Hisoka confronts the uncomfortable truth that he desperately needs people. He fled the terrible rupture of his infancy toward the *very thing he suffered exile from*: the face of the mother (mine), that existential place where he could be brought to his senses, where his life could be structured and rendered with purpose.

One day early this year, he sent me a photo of himself with a dog. He no longer wished to live alone, so he adopted a dog. Hisoka, an adopted child, now adopted a dog. He then brought the dog to session so that I could meet him.

Hisoka's case is a good example of the anchoring theme of this paper. Derailed attachments harmed his ability to embody a stable reality, making him alone when he was so young that he did not even know he was alone. His aloneness turned in on itself and fed his psychosis, which substituted anime for reality and a single room for the world. His parents carried him while he lived in the deadened womb of his room, facilitating his parasitic position. He felt miserable about that; he felt like a loser. The relationship with me eventually allowed him to anchor himself to the world, or, to put it more directly, to attain an embodiment that enabled functioning within it.

Loneliness in the Countertransference

A colleague who works with patients diagnosed with psychosis once told me about a man who arrived at his first session with two suitcases. He thought he was moving in. Since such persons often have difficulty with social relations, we sometimes become their sole human connection, the session the only time during the week in which they deeply interact with another human being. This is a privileged place to be. It can also feel like an enormous responsibility and a burden.

Therapists confront solitude as they listen to endless stories that leave them questioning the meaning of their patients' lives, their lives, and life in general. The analyst is Sullivan's (1940/2006) "participant–observer," the juxtaposition that comprises a paradox: engagement and disengagement, relatedness and solitude. Analysts simultaneously participate in the transference and countertransference while attempting to stand apart as an observer of the patient's and their own psychodynamics and defenses. In some cases, analysts sit behind the couch, out of view, a solitary figure set in a singular personal space, attentive to the patient yet open to private reveries, engaging the patient on conscious and unconscious levels.

Warren Poland (2000) rightly observed that silently witnessing the patient's self-inquiry is a major part of the analytic process, and Charles Hanly (1990) stated that genuine analytic work involves respect for the solitude of each person as he relates to himself. The analyst often feels alone and adrift in a sea of confessions. Though the analytic relationship is deep and intimate, cracking open the patient's most private and personal inner landscape, it by necessity must exclude the analyst as a fully expressive individual. Additionally, the analyst is forbidden to speak of these intense encounters because of confidentiality concerns. It is lonely work. At the day's end, the analyst may carry in her heart and to her home worlds of sorrow and loss, the angst of human existence along with its innumerable forms of pain.

Working with patients who exhibit psychosis can induce even more loneliness in the analyst. Therapists (especially beginning therapists) often feel frightened or lost when working with psychosis. They do not understand the patient's communication, or they feel unable to reach the patient to establish a therapeutic alliance. They may identify with the patient's hopelessness and despair or feel hopeless with regard to being able to help them. They may feel an absence of empathy for the patient's condition, or the patient might be angry over the therapist's aloofness. Collaboration may be lacking. Buechler (1998) compared working with the schizoid patient to having an unresponsive infant, working in a vacuum, sending a message in bottle out to sea, and hitting a tennis ball that doesn't return. All of these experiences can result in the therapist feeling disoriented, alone, unsure of her professional effectiveness, and, worse, unsure of her personal identity. Searles (1965) wrote that the schizophrenic patient drives us mad the way she or he was once driven mad. We are often made to feel the utter loneliness and alienation that our patients who experience psychosis feel.

Perhaps most importantly, the person diagnosed as psychotic reminds us what our sanity costs us in terms of lies and denials.

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They remind us that our character development does not simply accommodate the vector of our constitution and personal history; it defends against the nature of reality itself (the utter indifference of nature, the immensity of the cosmos and our smallness within it, the fact that our existence is an accident and yet matters so much to us, the heartbreaking fragility of all who we love or hope to love, the impossibility of having with others what we dream about, and the finality and annihilation of death). The psychotic in treatment stands with the therapist on the borderland between a humanly ordered world and the chaos from which humans draw order. The therapist must accompany the patient into that terrifying territory, one which the vast majority of "sane" people mightily repress and avoid. One is reminded of madness. One is reminded that one can go mad. And one is reminded that one's sanity itself is also a kind of madness. If reality itself is too threatening to bear, then psychosis can be seen as a process by which the imagination runs rampant, overpowering reason and the repression necessary for its proper functioning, creating delusions and hallucinations that mirror the tragedy of being human while creating a "world" that idiosyncratically expresses that tragedy while attempting to preserve life.

Each of us must do something when the gap between our social reality and desire for company becomes too wide, lest it become a devouring abyss. What we wind up doing with the gap is a vectorial result of the combination of our constitution, our personal history, especially its unconscious derivatives, and our conscious intent. The responses to existential and personal loneliness fall across a wide spectrum, though they have one thing in common: the need to have the other, whether person or thing. That other may be a new friend or love, a fully absorbing life project, religious or spiritual engagement, or an addiction in the form of alcohol, drugs, gambling, or sex. As we have seen, sometimes the other is madness itself—in the form of hallucinations and delusions or extreme seclusion. As analysts, we work with the last two components of the directional life trajectory, hoping to provide a therapeutic relationship that encourages the patient to realize life and form self-enhancing relationships. I'd like the close with another entry made by my writer/patient, Mr. L:

> When the burden of your existence has so little left to contain it, your very reality as a person is being destroyed. Without the rigor of an identity and the social scenes in which it is defined and belongs, you spill into a shapeless slick mess, like an oil spill, or jump from surface to surface like a fire out of control. You become a terrified animal who knows too much but not enough. Exiled from the homeland of your very self, no place inside or outside is safe, and there is nothing in you to separate the two. Everything is gone except a throbbing mass of sentience invaded by a strange and ugly world. Yet there still beats within you the tiniest of all hearts, a pulsing fist raging with white heat. Inside that clenched fist is a black piece of paper holding a request written in blood in a language bubbling up between the living and the dead. This is an ancient and universal language made up of the sounds of the night, of terrible loneliness, of mortal conflict, and of death cries, the lingua franca of original desperation. Translated that request says: *I am here. Please see me.*

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