Outpatient Treatment of Psychosis

Psychodynamic Approaches to Evidence-Based Practice

Edited by

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CHAPTER FOUR

Rethinking psychosis: attachment, developmental trauma, and the psychotic spectrum

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We are only just beginning to think about our thinking on psychosis. We do not understand the phenomenon sufficiently, let alone how it is caused. This very discourse, which is socially conditioned, presumes that psychosis is some sort of determined thing, something that is substantive and real, something medically objectified and classified, and that it has a biological basis or genetic aetiology. But those in clinical practice encounter different realities than those in the research lab. Psychosis never appears the same way. Why would we assume it has the same underlying mechanisms, let alone cause? Why would we lump human beings together into a socially constructed and contrived category? I must admit that I am uncomfortable even referring to a class of patients as "psychotic", as I feel this is disrespectful and displaces a person's human dignity; although I understand that we are cognitively disposed towards classifying phenomena, and as professionals we must hold a common language for communicating shared meaning. I suppose this label is due, in part, to the historical aftermath of the simple binary invented between the "neurotic" and "psychotic" to distinguish both, (1) a form of psychic structure, and (2) a level of severity in clinical presentation. Perhaps this gives us more

of a clue as to why we invent these binaries to begin with. Difference and differentiation underlie all classifications.

Mind is oriented towards differentiation, splitting, and bifurcation; and because of this cognitive propensity, humanity is compelled to see the world of phenomena in such fragmented fashions. But if things are divided, hence separated and splintered-off from one another, does this not speak to a primordial nature of mind revealing itself through a simple economy? We often hear of schizophrenia as being a "divided self"; but don't all human beings have a divided mind, in fact numerous divides? How do we make value distinctions of this sort when splitting and division are behind the structural processes of thought?

We should never assume that the label "psychosis", derived from the ancient Greek ψύχωση (*psukhosis*)—which literally means animation, or "giving life to"—applies to a mere anomalous subgroup of psychiatric patients. It does not, for it applies to us all. It is only in modern times that psychosis came to signify mental derangement. Even here, we must admit, that we have no professional consensus on what constitutes derangement based on the cultural and linguistic relativity of definitions of normativity and abnormality.

May I suggest that we do not truly understand the mechanisms of psychosis, nor its true cause, let alone how to treat it optimally. I suppose using brain language promulgated by cognitive neuroscience and genetic biology is enough to satisfy the medical profession, and certainly the pharmaceutical industry, but it has limited therapeutic currency and crippling theoretical shortcomings that are barely addressed by the multidisciplinary field of mental health. Because the behavioural sciences cherry-pick subjects and manipulate data in such a way through their so-called "objective" research studies, hence championing the gold standard of "scientific knowledge", they often present a picture to the world that psychosis is merely due to biological determinism in need of pharmaceutical intervention and medical monitoring (including hospitalisation), rather than seeing the need for talk therapy. Even a moron knows that a moron needs to talk to somebody.

The community mental health movement has virtually died in North America. Treatment regimens are now predominantly chemical. Privatisation has replaced community commitments beleaguered by rotating political parties who could not care less about the future of their precincts (based on their inevitable finitude in political office), as well as a fickle society ready for change in an ephemeral world of appearances

that offers no stability. Although pharmacology may help with controlling florid symptomatology, there is very little encouragement among mental health disciplines to promote psychotherapy for the psychotic. And any discussion of personality structure, the attachment system, desire and defence, developmental trauma, interpersonal matrices, the social link, and the psychological needs and conflicts informing mental functioning are eclipsed for reductive explanations fixated on the neurobiology of thought disorder. Unfortunately, this form of medicalisation of the human being fails to adequately understand the intrapsychic and intersubjective complexities of psychotic states; nor does it address the real needs of patients.

The causal relationship between attachment processes, developmental trauma, and psychosis is a topic that continues to remain controversial when biological and psychopharmacological paradigms in psychiatry dominate our explanatory models and dictate current mainstream treatment regimes. Throughout this chapter I wish to revisit what we mean by psychosis, including examining its essential structure, and argue that it forms a core in normative human thought and mental functioning, but with the following caveat: it manifests on a spectrum of clinical symptomatology and dysfunction. The interdependency of attachment variables that inform self-structure will also be explored in the context of three abbreviated case studies that involve various forms and gradations of developmental trauma. The first involves an unmedicated paranoid schizophrenic who was a child musical prodigy; the second a delusional police officer; and the third an elderly man who was fully sane until he was revisited by ghosts from his traumatic past—all of whom were seen in outpatient practice. The question of whether a psychotic spectrum exists within clinical populations, and can emerge based on psychological organisations alone, will be examined in relation to the popular governing view of biological determinism. Regardless of the aetiological factors involved, practical matters in treating the psychotic spectrum in outpatient environments will be a principle focus of this project.

The psychotic core

Is psychosis a normative and universal feature of the psyche? Does it have a developmental correlate beginning in infancy that becomes suffused in the structuralisation process inherent in personality formation?

These are not idle questions, for if the answers are yes this would mean that psychosis is a necessary aspect of psychic organisation. In other words, it is not merely accidental, acquired, or contingent upon extrinsic conditions or cultural environs, but psychogenically determined a priori.

Psychoanalysis has traditionally assumed that a psychotic core lies at the heart of psychic organisation inherent in both normativity and madness (cf. Eigen, 1993). We may historically observe how this assumption was posited by Freud and solidified in classical theory beginning with the primacy of unconscious fantasy and hallucinatory wish-fulfilment in early infancy, only to be radically developed by the Kleinian school in postulating an early developmental model that places psychotic process at the fount of psychic structure. Here the infant is believed to be besieged by persecutory and fearful anxieties and destructive impulses that have been split-off, projected, and reintrojected back into psychic structure characteristic of paranoid-schizoid processes (Bion, 1957; Klein, 1946). This assumption further led developmental theorists to consider rudimentary solipsistic and symbiotic stages, fragmentary structures, uncohesive self-states, and autistic positions that have a psychotic nucleus at their origin (Kernberg, 1975; Kohut, 1971; Mahler, Pine, & Bergman, 1975; Ogden, 1989). But can this line of thinking be sustained today? Or does this speculative theorising merely perpetuate its own psychomythology?

With current findings from infant-observation research favouring attachment theory (Beebe & Lachmann, 2014; Cassidy & Shaver, 1999; Fonagy, Gergely, Jurist, & Target, 2002), the proposition of normative psychotic processes are largely drawn into question; hence attributing psychotic phenomena to attachment dysfunction, disruptions in internalisation, structural disfiguration of a cohesive self, and early developmental trauma or abuse fuelling disturbed self-representations, faulty object choice, and maladaptive interpersonal relationships (Fonagy, 2001; Mills, 2005). That is, when psychotic processes are later detected in people, this would be correlated to the biologic-progressive interactions produced by the attachment system or infant–mother dyad, and would apply to abnormal populations rather than observed or ascribed to normal developmental sequelae. In other words, insecure, dysfunctional, and disorganised attachments can condition or lead to psychosis, not that it is innate to begin with. This conclusion further challenges modern psychiatry and neuroscience with its emphasis on biological,

chemical, and genetic essentialism as the culprit behind the aetiology of psychosis. Here neurobiology or genetic determinism undergirding psychosis theory must seriously contend with how attachment and cultural processes affect the development of psychotic organisations that are recalcitrant to materially reductive and simplistic models that prejudicially and politically drive the education, training, and economics of psychiatry today. As long as the field of medicine continues to brainwash the public, healthcare providers, and insurance industries into believing that psychosis is only a genetic disease and only treatable by psychotropic medication, then the pharmaceutical and medical monopoly will only get richer, and those suffering from various forms of psychosis not helped by medication regimes will go unsuccessfully treated unless one is encouraged to enter into psychotherapy.

But let us return to the question of whether there is any plausibility in proposing a psychotic normativity that lies at the heart of psychic organisation for all people universally. Is psychoanalysis guilty of committing a genetic fallacy when positing a psychotic core? That is, can the presence of any psychotic process (e.g., disordered thoughts that defy objective reality, ego dystonic fantasies, delusions, hallucinations, and so forth) be traced to earlier psychological configurations that comprise the ontogeny of the self within a psychosocial matrix that forms the building blocks of psychic reality? Despite advances in infant-observation research, the bottom line is that we can never truly know what an infant is thinking or experiencing internally (Stern, 1985). Epistemologically we are exempt from ever knowing. Here we may say that the question becomes hopelessly moot because it eludes direct empirical inspection, as all we can do is infer from observation and offer retroactive interpretations that conjecture to explain what we think is going on inside a baby's head within its current environment. Whatever explanatory models we offer are ultimately speculative, even if based on inductive and abductive arguments, which are largely devised to pragmatically help us deal with theoretical conundrums and guide clinical praxis. This is why, I argue, any psychoanalytic model of infantile development entails an explanans grafted onto an epistemologically foreclosed explanandum that is proffered to help us neutralise our ambiguity when encountering psychological phenomena not open to extrospection by virtue of the fact that it may only be known through first-person experience. From attachment researchers focusing on representational models, affect regulation, and mentalisation functions operative in the

development of the self, to contemporary Kleinians hypothesising about the primitive anxieties and fantasies that beset the infant in the first months of life, our diverse theories allow us to navigate the turbid waters of uncertainty any science or humanities wishes to mitigate.

Although I will be focused on clinical phenomena shortly, we may reframe the question of the normative universality of psychotic process as a logical posit. I have argued that the mind is dialectical from its inception, and a basic dialectical logic of differentiation, modification, and synthetic reintegration accompanies all psychic development in our process of becoming (Mills, 2000a, 2002a, 2010). Here I have relied heavily on Hegel's dialectical logic, but have offered my own amendments and emendations based on the observance of clinical and cultural regression, the selective process of internalisation and retention, and the abolition of any grand metaphysical absolutism that informs the process of sublation (*Aufhebung*). Rather, mind developmentally forges its own internal structures based on dialectical oppositions, differences, complementarities, and unifying principles that both expand and elevate its internal structure, but with the stipulation that the structural machinations of negation and conflict ensure that individual and collective life will always be infused with pathos. What this means is that it is possible for mind to slip back to previous primitive forms pressured by fragmentary, unmediated, irreconcilable divisions or fissures in the psyche that are inchoate and equiprimordial, what may not be inappropriately called psychotic in nature regardless of a person's capacity for healthy functioning.

The process of thinking and the ontological divisibility of the psyche

If psychic life is conditioned on a primal polarity that vacillates in, between, and through negation, opposition, and difference, then a basic splitting or rupture lies at the crux of mental functioning (see Mills, 2000b). In fact, we may say that splitting lies in the very act of thinking itself, for mind institutes division and separation in any cognitive operation by apprehending, breaking-up, and mediating objects. This is central to Hegel's (1831) Logic as progressive dialectical mediation that at once negates or annuls opposition, while at the same time incorporates or subsumes such opposition through the very act of elevating itself in a new mediated dynamic. In other words, thought generates, confronts,

and vanquishes difference as it integrates it within its own psychic reality while transcending its immediate experience in a higher synthetic unity that the very process of logical mediation brings about. Sublation (*Aufhebung*) is Hegel's term used to describe the dialectic that at once cancels, preserves, and elevates opposition within a higher developmental achievement that the mind actively constructs. This complex process transpires in the rudimentary operations of thinking and cognition; as mind generates various divisions and chasms via its entry into antithesis, it is compelled to shore up and reintegrate back into its internal structure. It is in the act of radical negation or splitting where mind first institutes itself as thought. Here we may see the seed of an inherent pathology: cleaving, dividing, chopping-up objects in thought opens us to our inherent emptiness and incompleteness, the very nature of desire as being-in-relation-to-lack. Mind is always in a divide, hovering in and out, over and through, its separations or gaps in being.

How would this process appear as psychosis? And more specifically, how would this appear to the psychotic? Following Hegel's lead, psychosis would appear as the inability to sublate or mediate objects in thought. This would at the very least imply a failure to adequately synthesise or unify representational objects of self, other, and world into a rational or meaningful structure. I further suggest that such a failure at dialectical integration would involve an attenuation of (or even a possible foreclosure of) sentient-affective mediation and the obstruction of semiotic linkages necessary for furthering the representational process of sublation. Put tersely, the psychotic lives in the gap. Here there is no mediated synthesis, no integration of imago, emotion, and meaning, only fragmented and fragmentary experience. In Hegel's language, the psychotic is confined to being-in-itself rather than being-for-itself, hence relegated to one-sidedness and schism. But as Hegel (1830a) continues to tell us,

> this stage of schism must itself be sublated in turn, and mind must return through its own agency to union with itself. This resulting union is a spiritual one, and the guiding principle of that return lies in thinking itself. It is thinking that both inflicts the wound and heals it again. (§ 24, *Zusatz* 3)

Here Hegel intimates how thought produces both psychic pain and healing, which is not only therapeutic, but spiritual. Spirit or mind

(*Geist*) is Hegel's term for the psyche at the zenith of its development, which is dependent upon the dialectical progression of the unconscious soul encased in immaturity and early developmental conflict. Following Hegel's logic of the dialectic, the general mechanism behind therapeutic action lies in the increased ability to achieve sublation at various levels of mental representation, from the life of embodied desire to the feeling soul and rational cognition (Mills, 2002a). But this is a continual process that is never static or complete, for the dialectic is always engaged in an active process of encountering new experiences it must continually mediate and integrate into its psychic interior, without which, the dialectic, hence mind, would cease to exist.

We are never unified in our psyche, never fully cohesive or complete in our being, for mental life is a meandering stream of entering in and out of a more fundamental fracturing of psychic reality that transpires within spacings of the abyss. We may venture that such a primal space or tearing of the psyche radically resists other holistic processes fighting to achieve synthetic integration and unification of opposites because psychic life is organised on sublevels of subjectivity that tend to compartmentalise and preserve idiosyncrasies and particularised experiences, hence constituting its own internal worlds which it safeguards through unconscious fantasy systems. I have referred to this ontological process as the institution and emergence of "unconscious schemata" (Mills, 2010), the building blocks of psychic reality. Because there is no absolute discernible locus or point of synthesis for the plurality of unconscious life, this ensures, at least logically, that we all experience fractal gaps in being. The persistence and repetition of such psychic gaps that are presumed to exist and manifest in us all, suggest that all human beings have a psychotic nucleus or fault line that can be breached or occluded given the right set of contingencies.

I propose that behind every personality structure lies a psychotic process, whether hiding dormant or in disquieted abeyance, or percolating benignly until the right stimulus or catalyst arouses it from its unconscious slumber. I do not mean this applies only to clinical populations, but to all people. Any of us are capable of having psychotic experiences, under the right strain or circumstances, even if this seems implausible upon first reflection. Following the principle of sufficient reason, every mental object stands in relation to its original psychical process; therefore, we may conclude that the divisibility of the psyche (including the bifurcation of drives, affect, imago, and thought) becomes the ontic

foundation upon which mind rests. In other words, the psyche is fundamentally split, and out of this antediluvian divide comes its myriad appearances. This primordial bifurcation of the psyche is destined to leave a certain element or remainder mired in negation, conflict, and destruction, the very qualitative properties characteristic of psychotic experience.

The notion that experiential gaps in being are punctuated by the imaginary register yet remain foreclosed in the real is compatible with a basic line of reasoning that situates splitting, primitive projection, paranoia, persecutory and retaliatory aggression, fear of externality/the Other, and general schizoid processes within the early formation of a sense of self. I would also argue that this compatibility in theoretical models is bolstered by evolutionary psychology, avowing how basic overdetermined dynamics of fear of predation, injury, mistrust, need for attachment security, and identification with familiar objects and environments in the service of self-stability and survival are instinctively natural and hard to resist. Here this leaves us in the dialectical gap between the fulfilment of drive and desire, and the pursuit of sublation and completeness on the one hand, and the inevitability of failure, dissatisfaction, impasse, and incompleteness on the other, for we can never live up to our own fantasies and ideals nor fill the lack. Whether this applies to the notion that our self-image is always fractured and imperfect due to human frailty, to our deep pervasive needs and unconscious longings that pine for satisfaction, psychic reality constitutes a series of spacings that are never whole or unified, for mind is always in turbulent flux as being in becoming.

Mind as projective identification

In my book *Origins: On the Genesis of Psychic Reality* I demonstrated how the dialectic of desire forges the progressive path of ego development that emanates from the unconscious abyss of indeterminate immediacy to the determinate immediacy of the unconscious ego to that of conscious life (Mills, 2010). Thus, the unconscious mind is an original undifferentiated unity that emerges from its immediate self-enclosed universality to its mediated determinate singularity. This is initiated through a dialectical process of internal division, self-externalisation, and introjection as the reincorporation of its projected qualities back into its interior. Here lies the basic process of projective identification: unconscious

agency splits off certain aspects of its interior, externalises itself, and then reconstitutes its Self by identifying with its own negated qualities, which it regathers and assimilates back into its unconscious framework. Through the complexities of mediation and sublation, the psyche achieves higher levels of unification and integration through rational self-reflection and the attainment of self-consciousness, thus uniting more infantile experiences and earlier movements within its more mature organisation.

Negativity, aggressivity, and conflict—the hallmarks of death—are essential forces in the thrust of the dialectic, a process Melanie Klein emphasises in her characterisation of ego development. The initial forms of the mind inhabit an undifferentiated void with the inner ambience of violence. It experiences the primeval chaos of an intense longing to fill its empty simplicity, desire being its form and content, the desire to fill the lack. Through the drive towards self-differentiation, the unconscious ego defines itself as a determinate being-for-itself and thus effects the passage from the universal to the particular, from a unity that lacks difference to differentiated plurality within singularity. There is an antediluvian cycle of negativity that we may say belongs to the prehistory of the conscious subject, a circular motion of the drives that constitute the dialectic of desire. Awakening as sensation from its nocturnal slumber, the feeling soul remains the birthplace of what is the substance of the "heart", for the abyss is the midwife of mind.

Klein's theory of splitting has revolutionised the way we understand ego development. For Klein, the ego exists at birth and is plagued by anxieties characteristic of psychosis, which it attempts to fend off and control through the primary defence mechanisms of splitting, projection, and introjection, thus giving rise to the paranoid-schizoid and depressive positions that mould object relations and psychic structure. Although Klein refers to these defensive manoeuvres as "mechanisms", they are not mechanistic. Ego activity is never fixed or static and does not take the form of predetermined tropisms; rather, psychic organisation is the continuity of subjective temporal processes distributed throughout spacings of the abyss. It is more accurate to conceptualise these early mechanisms as defensive process systems comprised by the ego's intrapsychic relation to itself and its object environment, initially the mother. This makes ego development and object relations an intersubjective enterprise.

In her seminal essay "Notes on some schizoid mechanisms" Klein (1946) proclaims splitting as the original primordial defence, a process she started analysing as early as 1929. Beset by the death drive (*Todestrieb*), the immature ego deflects the destructive impulse by turning it against the object accompanied by oral-sadistic attacks on the mother's body, thus giving rise to persecutory anxiety. Splitting is the very first in a series of defences that are never completely separate from one another, hence forming the dialectical cycle we have come to label as projective identification. While Klein cogently articulates the gradual evolution and strengthening of the ego, she concedes that "so far, we know nothing about the structure of the early ego" (1946, p. 4).

Not only must we situate splitting at the inception of psychic development, we must also demonstrate that splitting is the earliest activity of mind. Splitting becomes the prototype of mental process and remains a fundamental operation in the normative as well as in the pathological functions of the psyche. The unconscious ego first undergoes an internal division of (or separation from) its interior, which it projects as an external object within its own internality, only to regather and again make it part of its inner constitution. This primary splitting activity is architectonic, thus forming the foundation for psychic growth. Since splitting is identified as the initial movement of the dialectic, thus effecting its transition into mediatory relations, it becomes easy to see how splitting becomes the archetype of later ego activity, which Klein emphasises in her developmental framework. But unlike Klein (1946, 1955), who repeatedly tells us that the ego's first object is the mother's breast, it would follow that the ego's first object is itself—its own internality. The ego must first posit and set itself over its initial immediacy, which it does through splitting.

In "Splitting of the ego in the process of defence," a posthumously published unfinished paper, Freud (1940e [1938]) addresses the notion of disavowal and the "alteration of the ego", which goes beyond his earlier treatment of splitting in cases of psychoses (Freud, 1924b, pp. 152–153) and fetishism (Freud, 1927e, pp. 155–156), which is now included within his general theory of neurosis. Freud, like Klein, generally sees the conceptualisation of splitting as a defensive process that is usually confined to the domains of conflict, while our emphasis on the internal divisibility of the unconscious ego makes splitting a generic process that may be applied to any mediatory aspect of division and negation within the mind. In fact, it is negation that is technically the

first movement in the process of splitting, for division and difference are based on a determinate judgement or mediatory relation to antithesis, the initial form being denial or abnegation—the determination of the not. In *New Introductory Lectures*, Freud (1933a) is clear that splitting is a general ego operation: "the ego can be split; it splits itself during a number of its functions—temporarily at least. Its parts can come together again afterwards" (p. 58). Freud also alludes to an innate and normative function of splitting as it is applied to the synthetic processes of the ego. He states: "The synthetic function of the ego, though it is of such extraordinary importance, is subject to particular conditions and is liable to a whole number of disturbances" (Freud, 1940e, p. 276). Although in several places in his previous writings, Freud emphasised the synthetic functions of ego unification (Freud, 1926d, pp. 97–100; 1926e, p. 196, 1933a, p. 76), which had always been an implicit part of his theory, we can show that splitting is a basic psychic operation that may take on more pathological configurations throughout development, such as in the cases of psychotic and schizoid disorders articulated by Klein and her followers or in pathological narcissism and borderline personality, a topic that occupies much of the personality disorders literature today.

In its ego explicitness, before the soul makes its final trajectory to consciousness, unconscious mind has already undergone a manifold splitting of its interior by its own hands. In each incremental process of splitting that accompanies sublation there is an internal division, projection, and (re)introjection of its particularisation back into its internality. Each introjective manoeuvre is a reincorporation of its projected interior that takes place through an identification with its alienated shape(s), which it takes to be an exterior object possessing its internal qualities. Such projective identification may be said to be the truncated recognition the ego has of itself through the process of introreflection as self-reflexion—itself a preliminary form of unconscious self-consciousness—except that the ego has undergone a splitting as an element of defence against its unconsciously perceived conflict, which subsists due to the negative tension of the dialectic (see Mills, 2002a, pp. 35–36, 104, 107; 2010, p. 150).

As noted, this continual process of internal separation, projection, and introjection as reincorporation is the general structural operation of projective identification. The ego projects its internality as alienation, comes to recognise and identify with its alienated qualities, then takes hold of and repossesses its earlier disavowed shapes. It is through this

continual elevating process that both the content and the developmental hierarchy of the mind become more complex and sophisticated. The unconscious mind comes to take itself as its own object through its incremental reflection into its self once it projects its interior as its exterior, reflects upon it, and takes back into its internality what it perceives to be the externality of nature or otherness that it cognises (cf. Hegel, 1830a, § 384, *Zusatz*), and thus, effects a transition back into reunification. In other words, mind reflects into itself and sees it has projected its own thoughts onto the external world and misconstrued its internal reality for external objective facts. The mind is continuously engaged in this dialectical process in all its shapes; however, at this level in the ego's development, unconscious agency displays an early form of self-recognition through its projective identification as mediated self-reflection.

But why would the unconscious ego need to split itself in the first place? Here enters the force and primacy of denial (*Verneinung*). As previously mentioned, the ego's original activity is one of negation: it defines itself in opposition to what it is not. Following Freud, Klein speculates that splitting mechanisms arise in an effort to subvert the death drive that threatens the ego with internal destruction. Splitting is a defence against felt or perceived annihilation. As I have argued, unconscious subjectivity first encounters an inner negativity, aggressivity, or conflict, which becomes the impetus for dialectical intervention. In fact, splitting itself is a violent cleaving operation that divides subject from object. For Klein, splitting disperses the destructive impulse, while for Hegel splitting is destructive: it destroys as it negates. But the destruction incurred by the cancelling function of the dialectic is also preserved in the same moment as the ego sublates itself to a higher state. Splitting and projection highlight the negative side of the dialectic while introjection serves a synthetic function. The repetitive process of projective identification may be applied to the general ascending thrust of sublation or it may succumb to contentious dichotomies that are mired in chaos. Although the relationship between the death impulse and negation still remains equivocal, destruction is nevertheless a key element in the progressive unification of the ego.

In several works, Klein (1946, 1952) underscores the point that the ego is oriented towards higher degrees of unification. Elsewhere she states: "Together with the urge to split there is from the beginning of life a drive towards integration" (Klein, 1963, p. 300). This is the

affirmative and ongoing drive of the ego, which forms the edifice of the Hegelian dialectic, a proclivity that inevitably strives for wholeness and that Klein herself endorses. Hegel's emphasis on holism anticipates Klein's (1960) advocacy of a well-integrated personality, the goal of which is to master early developmental frictions that arise from persecutory anxiety and its vicissitudes.

But for Hegel and Klein, there is a dual tendency for both progression and regression, for both elevation and withdrawal to previous points of fixation. As Klein (1946) puts it, "the early ego largely lacks cohesion, and a tendency towards integration alternates with a tendency towards disintegration, a falling into bits" (p. 4). Hegel refers to this disintegration as a fixation and/or regression to the form of feeling—the original self-enclosed simple unity of the feeling soul, a dynamic responsible for "madness" (see Hegel, 1830b, §§ 403–408). We may further conclude that impediments to sublation underlie all forms of pathological dissociation. Like Klein, who stresses the primacy of developmentally working through the paranoid-schizoid and depressive positions, Hegel sees mental health as the ability to achieve holism through sublation: while feeling is never abandoned as such, it is subsumed within the higher instantiations of self-conscious rational thought. Even Klein (1963) herself says that "the urge towards integration, as well as the pain experienced in the process of integration, spring from internal sources which remain powerful throughout life" (p. 313). For Hegel, this would be tantamount to the labour of Geist, an arduous, poignant crusade. If the subjective mind is not able to developmentally progress towards synthetic rational integration, then earlier primitive defensive constellations will persist unabated.

Attacks on linking

Although Klein (1946) first defined projective identification as a defensive process expressed through splitting and schizoid mechanisms, she later (1957) suggested that envy was intimately embedded in projective identification, a process by which the ego forces itself into the psychic reality of the other in order to destroy its coveted attributes. Shortly after this theoretical modification, Bion (1959) distinguished normal from pathological forms of projective identification, which has further led revisionist Kleinians to articulate many distinct yet related modes of projective-identificatory processes (Hinshelwood, 1991).

Bion, himself analysed by Klein, was the first psychoanalyst to recognize normative functions of projective identification embedded in normal thought processes. Bion (1959, 1962a, 1962b) distinguished between two alternative aims of projective identification marked by difference in the degree of violence attached to the mechanism. The first, evacuation, is characterised by its forceful entry into an object, in phantasy, as a means of controlling painful mental states directed towards relief and often aimed at intimidating or manipulating the object. This is a pathological manifestation of projective identification. The second, communication, is a more benign attempt to communicate a certain mental content by introducing into the object a specific state of mind, a function often seen in the process of containing—a process in which one person contains some part of another. This is a normative function. It may be argued that evacuation is itself a form of communication, thus blurring the distinction; however, for our purposes, evacuation highlights the thrust, intensity, and urgency of the need to expel psychic content. In all likelihood, evacuation and communication operate in confluence separated only by their motives and the force of violence enacted through projection.

In his influential essay "Attacks on linking", Bion (1959) presents his mature view of projective identification as a form of communication taking on both normal and abnormal valences. Drawing on Klein, Bion depicts pathological forms as falling within a range of excess (e.g., the degree of aggressivity of splitting, hatred, intrusion, omnipotent control, and fusion with the object; the amount of loss or defusion of the ego; and the specific awareness of destructive intent). Normal projective-identificatory processes, however, play an adaptive role in social reality and are ordinary operations of communication and empathy, which furthermore transpire within the process of thinking itself.

Bion's (1957) model of thinking, linking, and phantasy is preliminarily addressed in his effort to differentiate psychotic from non-psychotic personalities, with special emphasis on the awareness of psychic reality (what in philosophy is typically called self-consciousness or self-reflection). For Bion (1954), drawing on Klein's (1930) and later Hanna Segal's (1957) work on symbol formation in the development of the early ego, the awareness of psychic reality is contingent upon the capacity for verbal thought derived from the depressive position. Yet this process goes back even further. Linking—the capacity to form relations between objects or mental contents—serves a functional purpose,

a process derived from the paranoid-schizoid position. Bion (1957, 1959) envisions psychotic organisation as largely plagued by violent attacks on the ego—particularly on the links between certain mental contents and the awareness of inner reality itself. As a result, the schizophrenic lives in a fractured world of terror, where mental links are "severed" or "never forged". Phantasy formation is fragmented, persecutory, and horrific. Attempts at linking conjunctions or making connections between objects are all but destroyed, and when minute links exist, they are impregnated with perversion and cruelty.

Bion's position echoes what the clinician experiences in his therapeutic encounter with the psychotic. The psychotic mind is besieged by radical negativity, structurally entrenched conflict, ego dystonic attacks on self-cohesion, and major distortions of self, others, and reality that cripple adaptive functioning and the subjective quality of life. Thoughts and objects are seen as alien processes that operate outside of one's agency and control and produce paranoia; feelings of torment, awfulness, and panic; and fear of total mind possession, splintering of the self, and death. Phantasy is taken for reality and logos has all but disappeared.

Splitting and the psychotic spectrum

Is there a basic fault line that may be breached under relatively normal conditions—let alone times of inner tumult or external crisis—that may trigger the emergence of a psychotic process? Rather than view this onto-structural a priori potentiality as a reified core or reducible centre of subjectivity, I prefer to view this fault line as an elementary or equiprimordial unconscious organising principle responsible for instituting division in the soul as a mode of psychic economy. Rather than view the psyche as psychotic at its core or foundation, itself a dubious value judgement, I merely want to highlight the double character of the dialectic inherent in both health and illness. Bifurcations, binaries, poles, and separations allow for the coexistence of difference despite their dialectical relations, and this reiteration of a simple economy allows for psychic differentiation threatened by diffusion or dissolution into an engulfing collective that vitiates all semblances of difference. Here a certain fear of engulfment and loss of self in the universal makes sure that difference is maintained through such divisions or gaps in being. This means that splitting is a necessary ontic condition of thought and psychic structure, and not merely a pathological instantiation or defence.

Given that every human being is preceded by a psychological attachment system, whether secure, healthy, faulty, deficit, or morbid, this means that personality formation first encounters splitting and division that is correlated to later psychotic experience. We may only observe how it appears predicated on developmental precursors. When splitting unearths a more fragmentary or traumatic process, it is more likely to manifest on a spectrum of psychotic organisation and symptomatology, which I have witnessed in my own clinical practice. That is, psychosis rarely appears in the same manner in people, despite the fact that we have good reason to believe a typology of psychotic symptoms and disorders are valid for diagnostic categories and/or social descriptions. Although negation, itself a form of violence, is the ontological force behind the splitting or cleavage of mind, which is furthermore a generic condition of thought, the unconscious operation of splitting objects remains its universal (abstract) form. It is only when particularised developmental, historical, and cultural contingencies are evoked that form carries forth tangible content that become intelligible to clinical sensitivities.

What becomes an important empirical question that potentially affects the clinical treatment of the psychotic is whether we should proceed with the hypothesis that some form of attachment pathology conditions the emergence of psychosis. This would further presume that some form of developmental trauma lies at the bedrock or essence of symptom manifestation, if not conditions the aetiology of disorders of this kind. Although I do not wish to make a broad causal claim or hasty generalisation to all psychotic populations, clinical observation alerts me time and again to how early developmental precursors in psychotic patients are correlated with compromises in early object relations and attachment relationships, experiential or perceived relational trauma, and deficits in psychic structure. I cannot recall a single psychotic patient in my career who I saw clinically that did not have some variant of these compromises in their developmental history. Because of my own experience, this clinical hypothesis forms a basis in how I conceive of psychosis as indices of traumatic attachment.

If we accept the premise that psychosis emerges on a psychic spectrum, from more benign or innocuous forms of inner conflict to severely pathological and disabling conditions that undermine the health and adaptation of the human subject, then what role does the dialectic of division and unification, difference and identity, splitting and integration mean for the patient? This dialectic is at the heart of

psychic organisation, which ensures that conflict remains its structural edifice. In this sense, conflict is at the core of the psyche in both health and pathology.

Not only is the failure of dialectical mediation and integration behind the emergence of psychosis, but so is the inability to float in the gap of difference—between division and synthesis, which also seems to be a dynamic behind symptomatic manifestations on the psychotic spectrum. The inability to drift in the gap of the gap becomes problematic for those lacking integrative cognitive capacities, especially when this is further blocked on an unconscious level. On one hand, there is a suspension of an integrative function that keeps a psychotic stronghold over the subject; while on the other hand, there is the failure to be able to suspend imagined realities as merely being a psychic projection. In either case, there is an inverse or double dialectic at work in both normative and psychotic thought, one being successful at both mediation and suspension, the other unsuccessful (even if disproportional) at performing either function.

If thinking is prefaced on ontological violence, namely radical negation—the cleaving of identicalness—then tarrying in the negative is the onus of mental functioning. But here we must differentiate ontological negativity from a phenomenological one. Just because certain self-states at times feel divided, nebulous, or incohesive, it does not mean our self is in shambles or falls to pieces. These are usually transitory phenomena at most, while structurally there is an ongoing sense of continuity and cohesion of the self despite its ever-changing dynamisms. Such vital processes are in fact what fortifies psychic structure and allows it to sustain, develop, and endure repeated conflict as a trajectory of dynamic pattern and temporal flux. It is only when this ontological tear in the psyche is incapable of sublating or leaving this divide that psychosis prevails.

The primordial split or gap that underlies thought and psychic structure may manifest in myriad fashions, from obsessive-compulsive fixations, amorphous confusions, disorientations/disorganisations, fugue states, merger fantasies, thought disorder, bodily somatic conversions (e.g., trichotillomania, anorexia, body dysmorphic disorder), circumscribed delusions, and so on that characterise schizoid, dissociative, and borderline phenomena, to full-blown chaotic and demented presentations where all semblance of cognitive order is inconceivably expressed as unreal meaningless nonsense, incoherent irrationality, and psychic

decay where no persisting cohesive self exists. Instead, any sense of self resides in the divide—fractured, maimed, irreconcilable.

What does this mean for clinical theory? Perhaps not very much. But if the psychotic is besieged by the inability to mediate and synthesise dialectical polarities or reside in the ontic gap of self-relation with all its ambiguities and challenges to both identity and difference, integration and diffusion, universality and singularity, then would not one goal of treatment be to help the patient tolerate such ambiguities so they can stand in the spaces, so to speak? Would not further treatment goals be to help the patient form social and semiotic links to help bind the irreconcilable divisions in his gaps in being? Regardless if psychosis or the capacity for its experiential manifestation is derived from normal or pathological development, patients suffering from psychotic states would still require a holding environment sensitive to their emotional fragility and ambivalent attachment needs. We can never underestimate how fragile a person can be, let alone what might set him off or lead to decompensation, or what may be the link that is broken which is sustaining his sanity, or the internal regulator that is eclipsed from rational decision-making when under the requiem of madness.

Setting clinical parameters for outpatient treatment of psychosis

It is very important for clinicians to consider practical matters when taking on psychotic patients in outpatient practice, even those who are prone to psychotic experiences, especially when the treatment is conducted in private practice or outside of a hospital setting or medical clinic milieu. I worked for years as a clinical psychologist in inpatient psychiatry dealing with floridly psychotic patients in individual and group therapy, interdisciplinary consultation, and assessment activities, before transitioning to outpatient private practice. The parameters are entirely different, as numerous clinical supports and multidisciplinary team approaches are often non-existent in private practice settings, hence requiring a carefully thought-out framework to treatment. This often includes having to consult and work with extended family members, the patient's psychiatrist and family doctor, external supportive agencies, insurance companies, and anticipating and being prepared for responses to crises, especially during the therapist's absences and during non-compliance with medication regimes.

The bald fact is that mainstream psychiatry today is not interested in conducting psychotherapy and would prefer to medicate almost all clinical conditions, especially when there are demands to meet a heavy caseload, or due to institutional restrictions where various political agendas are at play, especially when there are financial incentives to do so. Nowhere do we see this more evident than in the treatment of psychosis. But for good reason: a floridly psychotic patient is very difficult to treat. This is why working collaboratively with the medical profession is usually unavoidable, and depending upon the clinical presentation, medication management is typically the norm rather than the exception. In fact, it is prudent to have a consult (even if only on the phone) or a case management meeting with the patient's family and primary doctor during the initial phases of setting up a treatment plan so the patient is aware (even if minimally) of all the players involved in his care and the roles of each. I find this type of transparency and mutual collaborative support helps with clarifying ambiguity, solidifying structure, instilling hope, and in diffusing splitting, paranoia, and transference distortions that inevitably occur under these therapeutic conditions.

I prefer to establish a clear frame with the patient and his primary supports, which is usually a spouse or parents, and spell out my availability, when I return calls, times when I will not be available, and who to contact or what to do in crisis or times of emergency, including but not limited to medical intervention or even hospitalisation. Yet, I must add, this is done in a tactful manner that does not draw alarm or unnecessary anxiety, but rather is interpersonally finessed. Although a major goal for treating schizophrenia, let's say, is to keep the patient out of the hospital, there may be times this is a necessity, such as to prevent harm to self or others, or for medication readjustment, such as to manage prodromal or first-rank symptoms. In these cases, visiting the patient in the hospital and regular phone calls are crucial for maintaining therapeutic attachment, dispelling feelings of abandonment and aloneness, and helping in the transition process back to outpatient care. It is most often done pro bono.

As in most therapies, establishing a sense of trust and safety is a primary task that becomes recapitulated throughout the treatment even after a working alliance has been established. But this can be very difficult, and is always tenuous, especially for paranoids and those with active persecutory delusions. Often the "test" the therapist must pass is being

able to successfully convey a felt sense of emotional safety as unconditional acceptance of the patient's alien presence. I have often found that psychotics (like personality disorders, for lack of a better phrase) have a well-honed "shit detector" and are very perceptive and attuned to inauthenticity. Being honest, genuine, and spontaneous (without hesitation or reflection) in response to their questions and concerns aids in developing a trusting alliance and neutralise suspicion. I am much less inhibited as a clinician working with these populations rather than others, and am more concerned with demonstrating active listening, conveying interest and empathy, and in exhibiting a non-judgemental solicitation of their thoughts and inner world so that I can understand what they are experiencing. Here the withholding postures of abstinence, reserve, and silence are suspended and interpretation is held to a minimum. Instead, meaning is a collaborative exercise where I insist I am not the one who knows. To convey otherwise under the rubric of analytic reservation or pretension merely fuels paranoia or an omnipotent transference that suffers negative backlash down the road.

In encouraging free speech without constraints, I tell patients to talk about whatever they want and that my office is a safe place to explore their thoughts and feelings. When patients are experiencing active psychotic symptoms and express worry or question if I believe what they tell me, I suspend my own reality principle by focusing my attention on the patient's experience of reality as an empathic stance. Most of the time they are simply frightened and need emotional grounding and reassurance. When confronted on matters about objective reality, such as whether I see objects in the room that are not there, believe they work as a spy for the government, that God has chosen them for a special mission, and so on, I tell them I don't see what they see or know about these matters, but ask them to describe them to me, as what is most important is their experience and not mine. I find it useful to be up front about how their experiences and perceptions of the world are likely to be different than mine, and that does not mean I don't believe them or that they are invalid, but rather that our aim is to come to terms with what troubles them by talking about these things openly. I feel it is always important to have the reality principle in mind, because countertransference, experimentation, spontaneity, mental laziness, and so on can alter your perception of what is helpful.

In looking back at my therapeutic work with psychotics and attempting to discern a clinical pattern of therapeutic action, I would sum up

two principle features: (1) containment and (2) integration. Containment is accomplished by being present and reassuring during the experience of intense affect and disruptive periods of fear, paranoia, panic, and thought disorder (including first-rank symptoms), which often means sitting in receptive silence, providing a holding function, role adaptation and responsiveness, accepting the designated position of being a specific fantasy object, stifling one's emotions and behaviours, not overreacting by speaking prematurely or panicking or feeling compelled to take concrete action, and so on. Here the goal becomes more about binding intensities by introducing a calming felt presence that induces mimesis, which is furthermore soothing, and sustains continuity in the session. Containment is an ongoing function that allows the patient to internalise calming introjects over time through the continuity of the positive transference relationship. This also increases a sense of emotional stability and safety in the therapeutic dyad whereby a special space is increasingly forged and expanded for processing divisions or splits in the patient with the goal of integrating self-fragments and unifying oppositions in the psyche.

As we have said, psychosis is the failure of sublation, at least in part, which means a failure at sublation on the part of the ego, as well as fixation or oscillating between fixed presentations (*Vorstellungen*) and regressive withdrawal back to primitive shapes of mind that were once sublated. It is also a failure of being able to tolerate living in the gap of division, ambiguity, and fragmentary experience, that is, residing in the divide between irreconcilable oppositions. This creates a further ontic tension for the subject that is very uncomfortable to endure because attempting to mediate and integrate conflicting polarities at war with one another seems to be an impossible task. Here we may observe in the psychotic a basic defect or eclipse of a unifying principle or synthetic function necessary for trussing, transcending, and resolving intrapsychic fissures.

The inability to sublate opposition into a meaningful integration based on attacks on linking and/or in the failure to bind psychic division and competing dialectics operative in the mind, and hence resulting in semiotic foreclosures, seems to be a pathogenic element in the formation of psychosis. It would logically follow that introducing intervening cognitive skills at synthesising and integrating conflicting oppositions would be an overarching goal of treatment, yet this naturally takes into account working with micro-conflicts a bit at a time, not to mention

the assault on reason the psychotic experiences on an ongoing basis. What often happens in the consulting room is that patients get better at discerning conflicting stimuli over time and begin to enter into an inner dialogue where split-off aspects of the self come into communication with other alienated aspects, part self/objects, or micro-agents, and this juxtaposition increases the distinctness of particularity while decreasing its penumbral conflation with totality, which becomes lost in universal obscurity. In other words, units of experience can be identified and analysed without taking the unit for the whole gestalt of experience. A simpler way of putting it is that the patient is more able to recognise opposites in the mind as discrete experiences rather than as an engulfing totality where all aspects of the self are disoriented or eradicated.

Because psychotics often become overwhelmed with the immediacy of experience, they lose perspective, and therefore lack a self-reflective integrative function necessary to hold disparate experiences in abeyance from the big picture. This is why a firming-up of ego boundaries is essential in the here-and-now work the treatment demands when fixation, regression, or one-sidedness threaten the ability to cognitively appreciate how there can be a multitude of experiences that do not necessarily have to contaminate one's functional grip on inner life. But as we observe in our clinical work, even if there is some form of meaningful synthesis of experience in psychotic processes, there is still, nevertheless, an overwhelming pollution of emotion and blitz on safety and reality-testing that can corrupt all stabilising functions and plummet the patient into fragmentation, contagion, and decompensation. This is why containment, holding, and role responsiveness is the fulcrum of support that accompanies and allows integrative work to advance.

Treatment failure in working with a non-medicated paranoid schizophrenic

When working with psychotic states, the clinician often has to participate and tarry in the gaps and micro-divisions the patient experiences, including dealing with the unexpected and adapting in the moment to immediate surprises that are sprung on the therapist without warning. This also applies to praxis. Often we have to straddle the divide: vacillating between encouraging free thought to shoring-up loose boundaries; exploring inner experiences to discouraging active imagination

(due to being out of control with fantasies and perceptual disturbances); introducing containment, safety, ego strengthening, self-soothing, and reality-testing despite the traumatic nature of patients' inner reality that is stirred up by our questions and therapeutic work. When there are immediate confusions to penetrating questions and emotional breaches that exhume buried or dissociated inner realities or repressed memories and terror, psychotics get very frightened and they want to bolt. The fear of more fragmentation, of being more out of control of their minds, and the unconscious compulsion to repeat traumatic object relationships is destined.

Unlike some schools of thought that proclaim psychotics cannot link thought narratives to signifiers and signified or sustain meaningful symbolic mentation, I have observed in patients how there can be very intricate meaning systems and points of connection between the myriad images, thoughts, and affects they have in entertaining their delusions and hallucinations to the degree that they evince their own internal logic—despite the fact that there is a distortion of objective reality that is further altered by the projection of inner reality transposed onto the external world. Here the psychotic remains in the divide of his one-sided subjectivity and cannot hold the opposition of externality, alterity, and the objectivity of the natural world in dialectical symmetry, or does so tenuously, and thus is unable to perform basic cognitive mediatory operations that maintain the two sides of difference in relation to one other. This is most salient during florid psychotic episodes.

Consider the case of Jay, a twenty-four-year-old Taiwanese Canadian who had never seen a psychiatrist, been on medication, or been hospitalised. When he presented in my consulting room with his parents for the first time, he was floridly psychotic and paranoid. His parents were palpably nervous and relayed that he had been getting progressively worse over the past four years. They explained that he had been unable to complete his studies at the Royal Conservatory of Music due to a breakdown, despite the fact that he had been a child violinist who had performed with the famous cellist Yo-Yo Ma. Jay had remained in their care ever since, living at home and avoiding the social world. They relayed a history of childhood phobias, fear of others, anxiety, agoraphobia, and that "he can't be left in stores alone or around groups of people" without getting panicky and decompensating. As his parents spoke about his history of difficulties and their concerns, Jay's mind started racing and he spurted out a spate of ideas that were largely incoherent and

tangential associations, yet it was possible to discern an inherent structure and cryptic meaning despite his disorganised speech.

He spoke frankly of talking to God and felt he was a "filter for God's actions", but he was also angry at God for his suffering. He further said he struggled with being gay and being persecuted, only to have his conservative parents dismiss his feelings due to their apparent discomfort regarding sexuality. At this point he became very agitated. I asked his parents if I could have a word with Jay alone, and asked them to sit out in the waiting area. When they left the room and closed the door, I told him, "You look frightened to me. It will be OK if you want to tell me about it." This seemed to have an immediate calming effect, as he appeared more comfortable and started to talk. He started to ask me many questions, the details of which I forget. I felt I was being put through a test. The slightest misalignment in my understanding or attunement led to defensive reactions, and I felt I needed to mend the rift. He said that when he spoke Jesus's name he could command the appearance of God, and that he needed me to say "God loves America" for him to feel reassured. He was worried about his own death, the death of his grandfather and "old people" in general, and ruminated over his past mistakes during his musical performances. I mainly concerned myself with alliance building during this initial meeting, and when I asked his parents to return to my office at the end of the session, Jay said, "It is good, there is hope."

After setting a time to meet with the family to continue our initial consultation process, Jay's father gave me a book to review before our next meeting. It was *Dante's Cure*, by Daniel Dorman. I had not heard of it at the time, but after perusing through the introduction, I saw it was about the psychoanalytic treatment of a young schizophrenic woman who was brought back from madness by her psychiatrist without the use of medication. I immediately realised that the family were hoping for the same result. Later that week, Jay's mother called to see if we could meet sooner than planned as Jay had been very anxious and asked to see me. I saw Jay alone this time. He had pronounced thought disorder and was delusional, although there were no noted hallucinations present. His mind would race from one thought to the next in a disjointed fashion and was triggered by multiple external cues that produced unarticulated internal links. He was very sensitive to my body language and questions, and I could see he was vacillating between ambivalent and positive transferences towards me. He wanted me to adopt a certain role

responsiveness to his questions and requests with a calming-soothing introjective function, but when there was the slightest misattunement, this would trigger an alliance rupture and produce paranoia.

He stated he "felt exposed" and was "in pain". "Tell me about your pain," I replied. He became more fragmentary in his associations. I then realised I shouldn't rush him. Saying less was better. Both persecutory and grandiose fantasies followed, including that he was a child of God. I just listened. At the end of the session I thanked him for sharing his thoughts with me and said that I valued the fact that he felt able to do so.

By the third session Jay had decompensated. I could not track his loose associations and attacks on linking very well. He was bombarded by internal aggression, competition with others, self-flagellation, and rage through projective identificatory processes that became paranoiac. He was finding ways to please me in his verbalisations but was also beset by pressure to impress me with his insights and questions, which created more anxiety and interpersonal awkwardness. Here it was very easy to have an alliance rupture due to his inner chaos, lack of positive emotion, confusion, and my misattunement to his verbalised meanings I could not understand. But just when I thought the session was a disaster, he said, "I feel safe here." "You are safe," I replied. "Nothing will happen to you here. It's OK to tell me what you want to say." He then went on to tell me how easily he became afraid, and that he tried to suppress his thoughts, fears, and "secrets". Although he stated that he did not wish to "talk too much" of his pain and "inner hurt", he disclosed that his classical music education at a very young age was very traumatic due to his parent's insistence, and elaborated that in ninth grade he was very shy and submissive and spent most of his time isolating himself in the high school bathroom. He lamented how he felt a lack of connection with others and perceived their felt hostility, although he realised that his reasoning and communication "were off". This was followed by an allusion to confusion over his sexuality and the need to see me as "wise". Here I could discern the presence of both a sexualised and idealised transference, but it would have been premature to even draw attention to it.

Having already discussed my policy with the family during the initial session about having open communication with all members involved in Jay's daily care, his parents told me that he had ongoing delusions and hallucinations with first-rank symptoms, that he often claimed that

he saw God, and that he had told them he saw God in me during our first session.

In our fourth session he came into the office by himself with his violin, laid the case down on the floor while kneeling to open it, then pulled it out, stood up, and began to play Mendelssohn. At first he sounded like a recording in the concert hall of my office, when suddenly about one minute into the piece he made a slight mistake due to his performance anxiety, and then abruptly stopped. He attempted the sonata three times, then became too self-conscious and embarrassed, and put the violin away. When he sat down I told him it sounded beautiful. He fell despondent. I asked him why he had decided to share his "gift" with me, and all he could say was that he felt he had disappointed me. "I think you disappointed yourself, but not me. I am very impressed." What transpired after that was the felt presence that I was a calming-soothing introject while at the same time being a source of anxiety and ambivalence tinged with the pressure of him wanting to feel better and "learn from me", as well as the fear this evoked. He then went on to say he felt "scared inside and of God". When I asked him to tell me what he was scared about, this led to a rapid deterioration in coherence of speech and an overwhelming sense of panic. In my attempt to ground him and offer reassurance in order to bind the emotional contagion, I told him that "I think God sent you to me for help." He softened a bit after this and told me he felt I was "kind".

In looking back at this intervention, I believe it was motivated by my countertransference reaction in the heat of the moment and was ultimately not helpful because he came to his next session in a florid state of decompensation. He sat with his father present the whole time (as if he was an office fixture) and talked non-stop, meandering from disjointed topic to the next, yet perseverating on the major themes he had previously introduced of being scared and ambivalent towards everything, his past pain that he did not want to focus on, confusion over being gay or heterosexual and the need to speak about it but with fear of doing so, and the feelings of trepidation in my presence after talking about his generalised terror of God. At times his verbal productions were like word salads with no discernible meaning whatsoever. Here I simply sought to reinforce an ambiance of safety, security, trust, and containment.

Near the end of this fifth session, which is my typical consultation period, I asked Jay if I could speak to his father alone for a few minutes

while he sat in the waiting room. During this time his father told me that Jay was experiencing somatic conversion symptoms; he was hiding in the house and talking to the walls, felt his body was altered, and was generally out of control and not in touch with reality. I expressed my concern that he needed to have a consult with a psychiatrist for the possibility of starting a medication regime to control these pronounced psychotic symptoms, as he clearly presented as a paranoid schizophrenic who has had delayed onset since his teen years despite prodromal signs that were evident in childhood. Jay's father had already come to this conclusion in his own way, without knowing the technical language, but had hoped I could treat him in the same way that the psychiatrist in *Dante's Cure* had treated his patient. When I told him that this was a six-days-a-week treatment for seven years in an outpatient hospital environment, and told him what the cost would be, he quickly changed his mind claiming he could not afford it. I proposed that Jay continue with me on a weekly basis for as many years as it would take; I was careful to point out the reality of the situation, and advised that with medication management this may be an optimal way to proceed. Although we set up future session times, they were cancelled, the parents claiming that Jay had appointments to see his family doctor and a psychiatrist. I never heard from them again.

Living in the imaginary

Lacan's views on psychosis evolved as he adopted his tripartite theory of psychic reality, emphasising the systemic linking or knotting of the imaginary, symbolic, and real registers of mental functioning. Initially, he focused on the imaginary relation to the world—predominantly the realm of fantasy stimulated by images, followed by a foreclosure in the symbolic order—culture, language, alterity—as symptomatic of psychosis. Here we may say that psychosis is primarily a disorder of imago and meaning. Following Lacan's (1936) mirror theory of ego development, the psychotic becomes developmentally arrested at the level of its misrecognition and captivation with images, whereby it becomes difficult to differentiate between self and other, which in turn leads to confusion, ambivalence, and intrusive feelings of paranoia (Lacan 1947). Although Lacan (1955–1956a) later notes that psychosis, and particularly hallucinatory phenomena, arises out of "the subject's history in the symbolic" (p. 13), the meaning of delusions and the problem of paranoia are often driven by imaginary understandings (see 1955–1956b

pp. 20–21). In other words, what a person perceives, thinks, and interprets is rooted in a causally determined past (as our thrownness into biology and culture) that conditions our experiences through consciousness. This is no different than Freud.

What humans do is project their interior desires and conflicts onto everything around them. The main downside for the psychotic is that they cannot read between the lines and reserve, or restrain, their projections towards certain circumscribed objects. Instead they are cast off spuriously, without refrain, because there has been an eclipse in the reflective function that stays attuned as a more or less detached perceptive-adaptive ego that monitors its objective surrounds and conditions. Furthermore, there is an eerie contagion of affect and image that colours, suffuses, and warps the parameters and contents of what is experienced and communicated, so much so that at times the clinician is left with a befuddled unrealism.

Let us turn to the case of Bill, a forty-two-year-old police officer who was referred to me by someone he trusted because he was told I had a policing background. In fact, I had trained to be a cop in my youth and at the time of our initial work together I was a consulting psychologist for the same police service he was employed by, and he was fully aware of this. Bill was in a state of desperation as he was undergoing a suicidal depression and was having fantasies of putting his handgun in his mouth. We connected immediately as the positive transference had already been prepared. After a preliminary assessment in determining his risk for suicide, I encouraged him to go on sick leave so he would be relieved from his stress at work and could then attend to his mental health by seeing me regularly. After dealing with some initial resistance, I wrote a report for his human resources department so that he could go on leave.

Lacan's early theory of the imaginary nicely applies to this case because Bill perceived me to be like himself through an overidentification of sameness, and hence there was a fundamental misrecognition in the way we thought about and experienced the world. This was further facilitated by the fact that we both are men of large stature, shave our heads, wear beards, and are one month apart in age. He also viewed himself as a "good cop" who was "principled", and very much saw himself like me in a helping profession, with semblances and similarities in our views about humanity, which he presumed were compatible, yet with the stipulated distinction that he had to deal with the sickest aspects of the public on a daily basis and had to endure the hegemonic

politics of an oppressive police service that did not care for or about its walking wounded.

Bill felt persecuted at work and targeted by his superiors for his strong opinions, attitude problem, confrontational demeanour, and anti-social tendencies that led to him being disciplined and removed from his duties as a detective. Having been stripped of his professional identity and personal self-worth, he was contemplating murder-suicide. Once Bill had been removed from these immediate work stressors we began to examine the immediate parameters and source of his rage and depression, which proved to be a journey of detective work of another kind. Beneath the despair, helplessness, hopelessness, and need for revenge, was a sordid and traumatic past. Bill became a cop at the age of nineteen, and in the early days of police training there were virtually no screening criteria for suitability for the profession. During his first week on the job, he had to remove a dead body from a garage that had been cooped up there for weeks in the heat of summer, in a festering stench; and when he tried to pick up the body, the skin from the cadaver's arm slid away from the body in his grip as he began to pull it. He immediately puked. His colleagues spontaneously laughed and humiliated him, then went out for hamburgers as he remained in the cruiser feeling ill.

Unpacking Bill's developmental and work history led to another series of discoveries. Bill was seen as a "rogue cop" by his colleagues, which led to alienation from the brass. Throughout his career he had been in several high-speed criminal pursuits that led to many severe accidents, including seven concussions, head injury, herniated discs, and a mild heart attack, necessitating him to go on medical leave and enter into rehabilitative recovery several times. He was also shot at, survived a knife fight, and was almost decapitated by a Samurai sword during an apartment raid on a domestic dispute call. Rather than talk to others about his symptoms and the effects of his trauma, an unspoken prohibition in police culture, he drank himself to sleep every night.

Eventually Bill started to confess his sins couched under the rubric of "duty" and the moral imperative to dispense justice when justice was due. He displayed a cavalier attitude of knowing what was right from wrong based on natural law theory through his assessment of situations that were "self-evident" and in need of rectification. He told me of the many times he had physically abused others when they disobeyed his orders during arrests, kicked in people's faces while in custody, and stuck his gun into a detainee's mouth in the back of a patrol car until he

shat himself. When I asked Bill if his impulse to put his service revolver in his mouth may be connected to this past event, a paranoiac process of suspicion started to incubate.

Bill acquired a reputation for being a maverick within the police service and had several disciplinary actions brought against him by both the public and fellow officers, which led to conflict and loggerheads with his superiors. In the end, Bill believed, he "got shafted".

Why did Bill become a cop? He nobly wanted to help people. There is always a correlate between what a person does and values and how one acts and what they personify in the present moment, as every wish, fear, and desire is unconsciously encouraged. While there is always a correlation to the past, we should not equate that with causality, for this argument succumbs to a genetic fallacy. Our archaic experience does not determine our outcome or destiny, only the modes in which we are shaped. At most, our unconscious influences speak an honest truth. Bill was unconsciously impelled to become a cop because his father beat his mother during drunken stupors in his presence, and he felt helpless as a little boy unable to protect his mother while witnessing such traumas unfolding. In the end, through sublimation, he came to defend the helpless in need of security and protection, and had helped greater society in the process through practical interventions, not to mention fulfilling a cultural symbolic ideal that was essential to his personal identity. These are the public heroes we are often unaware of. But the dark side of Bill, the shadow of his father, left its own pathological debris.

Working within police and military culture is different from working with the public, as there are hierarchies of command, direct orders, strict codes regarding right and wrong procedures, prohibitions, and so forth, and hence the forms of splitting, division, blame, and responsibility can be more pronounced than in general work environments. There is a machismo image for police officers to be in control at all times, even among female officers, and this gives rise to heightened vulnerabilities in defence, splitting, shame, and paranoiac relations.

A paranoid nucleus was part of Bill's personality since he was a young child, given his attachment insecurity, exposure to violence, and the need to be vigilant at all times in a chaotic home atmosphere mired in uncertainty and abuse; so it was natural for him to transfer his heightened awareness, suspicion, and mistrust of others through the path of his profession. What I had not anticipated, however, given our strong working alliance, is that he would come to view me as an object

of persecution that developed into a circumscribed delusional system. Lacan (1955–1956c) tells us that "the very basis of a paranoid structure is the fact that the subject has understood something that he formulates, that something has taken the form of speech and speaks to him" (p. 41). Bill became more and more spooked and agitated by my questions, which he viewed as confrontational and accusatory, as though I was attempting to pry secrets from his soul. He in turn became hostile, and even threatened to come over to my chair and "smack" me. In my attempt to mend the emotional rift, I merely wanted to understand why he felt threatened by my questions in the first place, since I had had only good intentions to help. I told him that I had the feeling he was keeping things inside that he had trouble admitting and accepting, and that this was part of his symptoms—including daily panic attacks, generalised anxiety, agoraphobic withdrawal, suicidal ideation, somatic breakdowns of his body (including hospitalisations for various illnesses), and unbearable night terrors from his post-traumatic stress that at times violently woke him with haunting hallucinations that lingered on for days. I suggested they could be transformed if he spoke about them openly rather than trying to suppress them, as this was the best way to work through internal conflict.

My queries about what he had done spoke to him, and any suggestion that he was keeping secrets from himself was vehemently denied. But his paranoia intensified and his symptoms worsened. Here we may be reminded of Lacan's (1955–1956d) formula: "*what has been rejected from the symbolic reappears in the real*" (p. 46, italics in original), hence an unconscious remainder that must be projected back onto the imaginary as paranoiac knowledge. Bill began to question the details of my questions and my motives for asking them, to such a degree that he eventually accused me of working for the police to gather information to use against him in criminal proceedings. Over a few weeks, he held the conviction that I was working from the inside to build a case to have him brought up on manufactured charges. His genuine worry that the police service did not care about the mental health of their officers was not without merit, however. The service had acted in ways to simply want to blame him for "faking" his symptoms so he could be discharged without a pension. Despite the fact that I had fought for his rights through assessment and progress reports, a seed of paranoia convinced him I was a spy.

At the zenith of his fears and accusations, he thought my office was bugged with audio devices planted to record his confessions to crime

Even after pointing out the illogic and improbability that this was at all possible given that my office is in my home and that the police would have to infiltrate my domicile illegally, and unbeknownst to me, despite the fact that I work there every day and that my family live there, for which we would be aware of any noise or intruders, he still thought it was possible, especially if I was a "mole". "But that would cost tens of thousands of dollars," I replied. "Why would the police spend those resources on the off-chance fluke of hearing something from you when they have not presented any evidence against you nor have you even been charged with a crime? Why would you even remotely believe they would care about you that much to go to such lengths to buy me over to betray you when that would violate my ethics and put my license in jeopardy?" "How do I know you aren't wearing a wire?" he responded. At this point, I lifted up my shirt and showed him my bare stomach and chest and all aspects of my torso so he could see for himself. "Bill, as much as I like you and want to help, I would not throw away my livelihood for you." This immediately eased his suspicion, and his persecutory delusions abated shortly thereafter.

My gnawing suspicion was that Bill maimed or killed someone during the course of his career, and that he was suffering from unconscious guilt, which in turn would reproduce fears of discovery and exposure, and reinforce his paranoiac knowledge and fear of retaliation. Here the threat of retaliation was primarily introduced by his own superego as a failure of conscience and the need for punishment, but his employer's campaign not to support his disability claim fuelled his delusional fantasies. My suggestion that it would be best to clear his conscience so he could face his emotions honestly and work through his conflict in therapy only produced more symptomatic upheaval and paranoiac confrontations. Despite the fact that we had worked through his night terrors and trauma dreams, the tormenting deposits of his experiences on the police force, and his depression, alcoholism, and frequent panic attacks, he has yet to admit to anything so incriminating to this day. Although Bill is no longer dominated by the imaginary, having been in treatment for over ten years and now retired, he still faces the remainder slumbering in the real.

Trauma, attachment, and psychosis

Throughout my clinical career I have yet to encounter any who are prone to psychotic experiences and free of developmental suffering and

attachment disturbances, even if only minor in scope or intensity. When more pronounced forms of trauma, abuse, or neglect are identified, there is always a correlate to how attachment patterns have developed and are compromised in relation to feelings of safety, emotional security, self-cohesion, the construction of object representations, capacities for affect regulation, and the formation of psychic structure. Here we may say that psychotic symptomatology cannot be separated from attachment pathology and the presence of developmental damage. But the interconnectedness between trauma, attachment, and psychosis is often more salient when symptomatology emerges due to post-traumatic conditions.

Paul Verhaeghe and Stijn Vanheule (2005) hypothesise that the development of post-traumatic stress disorder (PTSD) in adults is necessarily predicated on the pre-existence of an "actual neurosis" that predisposes them to experience this type of disorder along with accompanying symptomatic, somatic, and anxiety-related sequelae; and that this neurotic structure is constituted in the early child–parent dyad as a failure of the Other to appropriately provide mirroring functions necessary for arousal and affect regulation, which informs the symbolic formation of self-identity. Verhaeghe and Vanheule conclude that "PTSD occurs in those victims who, prior to the traumatic incident, already had an actual-neurotic structure. It is precisely because of this structure that they are unable to process the trauma in a psychical, representational way, and as a consequence, develop PSTD" (p. 499).

I find this claim to be clinically verifiable on many accounts when applied to traumatised patients who present with chronic and complex PTSD with and without psychotic histories, which is readily confirmed in my own clinical work with such populations. What Verhaeghe and Vanheule refer to as actual neurosis I have referred to as structural disfiguration in personality organisation due to attachment pathology constituted as a disorder of the self and maintained on unconscious representational levels (Mills, 2005). From my account, what predisposes patients to experience future PTSD profiles, as well as most major mental disorders, including borderline organisations, anxiety and panic disorders, phobias and agoraphobia, affective and somatoform disorders, and the like, must be predicated on earlier deficits in personality structure due to developmental traumas that threaten the child's sense of safety and take place within the attachment system. This is no different for psychotics. Such childhood encroachments predispose

the subject to develop differential organisations and trajectories of psychic structuralisation that instantiate themselves as anxious, traumatic, fragmentary, depleted, vacuous, and aggressive valences. These structures are in fact process systems largely organised on unconscious levels of representation and meaning dominated by fantasy and defensive formations that comprise self-structure. From my perspective, future pathology is always conditioned on structuralisation deficits due to attachment disturbances early in life, which colour self and object representations, emotional constellations, identity formation, and psychosocial functioning. Here structural deficits are constituted through various forms of developmental traumata and hence, both logically and maturationally, necessarily predate and predispose the child to future vulnerabilities, which may explain in part the onset of severe pathology, including PTSD and psychosis. In fact, if actual neurosis is a precursor for the development of PTSD, would not a psychotic nucleus be a precursor to actual neurosis?

Verhaeghe's and Vanheule's (2005) controversial claim that "there is no direct connection between trauma and the development of PTSD" (p. 494) must be reconsidered in light of copious clinical evidence that explains psychic organisation and self-development based on encounters with early developmental trauma. Developmental traumata may be discrete, cumulative, and overdetermined with qualitative variations in the intensity, duration, and felt or perceived severity depending upon the subjective mediating factors that constitute the phenomenology of lived experience. Furthermore, these traumas are subjected to unconscious defensive organisations and fantasy formations that attempt to alter, symbolise, or represent the trauma. This of course impacts on internalised self and object representations and the formation of self-identity, which thereby affect both intrapsychic self-regulatory functions as well as intersubjective relations. Developmental traumata are mediated by the agentic unconscious ego and subjected to internal intervening relations despite the fact that such intrapsychic processes stand in relation to others. Because developmental traumas are often secretive and cryptic, thus relegated to the privatisation of subjectively internalised pain, psychic vulnerabilities and related structural deficits evolve as lacunae in self and object representations inherent in the ontogeny of self-structure. These internalised traumatic events, contents, and their derivatives largely consist of toxic and parasitic introjects that assail psychic structure and thereby predispose the subject to

future vulnerabilities, including the instantiation of symptomatology across the psychotic spectrum.

I believe we need to make a distinction between actual neurosis as a precursor to later trauma versus deficit personality structure as caused by developmental trauma due to attachment disturbances. We furthermore should be sensitive to the likelihood that earlier developmental precursors of splitting and negation encrypted in the very structure of thinking itself lends itself to developing psychic organisations that by their very nature are ontologically compromised in their very ability to integrate, synthesise, and symbolise polyvalent and multidimensional aspects of reality. What gives rise to a radical cleavage or declension between inner and outer dimensions remains a matter of dispute; but we are justified, I suggest, in speculating that the capacity to navigate inner and outer, identity and difference, one and the many are intrinsic tensions fuelling neurotic from psychotic adaptations to trauma.

If we accept the premise that deficit personality structures, which are internally organised (albeit compromised) process systems that can potentially explain, at least in theory, divergent symptomatic profiles that span across a wide range of pathologies, then this would certainly apply to the psychotic spectrum. In all cases of chronic and complex PTSD I have treated displaying psychotic features, I cannot recall one patient who did not have pre-existing developmental traumata and structural deficits that influenced, fed into, and/or exacerbated their current traumas, which subsequently incapacitated their ability to cope with and ameliorate their intrusive symptomatology. In other words, the precipitant trauma that triggers PTSD and psychotic reactions is actually due to the intrapsychic retrievability of previous trauma that the patient had hitherto sequestered, dissociated, repressed, compartmentalised, unsymbolised, and/or defensively kept in abeyance. In effect, present traumas open a once fortified porthole to past traumatic events and/or their representational, affective, and somatic reverberations, which were in an unconscious state of unrestful or disquieted slumber. In those instances, the present becomes merged with the past in temporal diffusion and PTSD or its variants subsequently become the symptomatic outcome.

The empirical literature largely confirms that victims of PTSD have functional deficits in the mnemonic representation of traumatic events, which cannot be remembered in associative, declarative, or narrative forms, and hence the inability to symbolise the trauma lies at the core

of sustaining its pernicious effects on psychic functioning. Although I do not dispute this general consensus, we must nevertheless revisit the question of the representability of trauma in the psyche. Verhaeghe and Vanheule accept the view from neuroscience that trauma is not stored in declarative or narrative memory, but rather is remembered in implicit procedural memory, and hence trauma cannot be properly represented in associative or symbolic narrative forms. While this may be true for many trauma victims, I have encountered patients who have had no trouble remembering what happened to them and can indeed describe such events in clear and articulate ways with appropriate metaphorical and symbolic articulation in their verbal narrative declarations. Here the problem was not so much the question of representation, but what kind of representations were simultaneously operative, as well as how they were mediated by the subjective mind.

Consider the case of Mr P, a successful educated business man, who at the age of sixty-five began to develop severe suicidal depression in response to his inability to manage his overwhelming traumatic symptoms, which he had harboured his whole life. He had been subjected to horrific physical violence, repeated sexual abuse, and perverse cruelty at the hands of his step-father from the ages of six to eleven, and before that he had been physically abused by his biological father from the ages of two to four. When living with his biological father and mother on a military base in his early years, he was readily expected to perform duties and obey orders just as his father did. When he failed to make his bed sufficiently to pass inspection, his father would strike him and once made him drink a glass of vinegar. When he refused his step-father's requests for fellatio on private outings, he was tied up to a post in the basement and beat like a dog before he was sodomised. He furthermore witnessed his mother on several occasions being beaten and left unconscious and bloodied by both of her husbands as he watched in terror while trembling in extreme fear and helplessness. The actual memories of these events were burned into his consciousness and had tormented him his entire life, thus leaving a massive structural depletion despite his financial and occupational success and happy marriage. It was only when he started to feel the decay of his body due to old age and arthritis that the earlier memories evoked his feelings of childhood helplessness and their traumatic aftermath.

Mr P characterised himself as chronically joyless and self-loathing, which eventually led to five suicide attempts in response to unremitting

nightmares of his assaults and flashbacks that took on psychotic properties in the form of hallucinatory persecutory images that visited him during the day. These visitations were likely projected unconscious representations of his perpetrators (or their condensations), but his cognitive appraisal and associational narration of them as such did not diminish their internalised presence. They had acquired an ego dystonic organisation despite the patient's subjective realisation that they were only re-presented images and memories of his past.

He was furthermore able to write about his traumas in several journals, in poems and short "fiction" stories, and they were apparently sublimated, so he thought, through artistic endeavours and physical sports (such as through painting and the martial arts). His ability to symbolise, articulate, and represent his trauma in verbal discourse, however, was less fluent and much more difficult for him to share in vivo because he bore the shame and crucible of his internally damaged core. His reluctance to speak out loud about the details of his sexual abuse were a primary obstacle to his recovery. This was complicated by the fact that he had privately internalised his pain his whole life, never speaking about it to anyone including his wife and children, and, like so many trauma victims, was scared to death to speak about it because as a child his step-father had threatened to kill him. A main point I wish to make here is that higher modes of mnemonic representation were achieved although therapeutic transformation was stymied due to Mr P's inability to verbalise and work through the details of what he had actually survived. He made a subsequent suicide attempt following an emotional session in which he felt he had not survived, thus triggering the onset of more waking hallucinations that took the form of ghosts and flying demonic faces he could not fight off or will away. His case was so severe, that after he acknowledged for the first time to any human being what had happened to him, he drove his SUV out into a remote area in the middle of a snow storm, shut his car off, took an overdose, and hoped he would freeze to death. When that did not work, he set a small fire in his barn and laid down hoping he would pass out and be asphyxiated. After a brief hospitalisation, we resumed our work together.

Verhaeghe and Vanheule (2005) maintain that trauma is not psychically mediated, but rather, if I understand them correctly, it is somatically channelled, contained, and/or converted. In fact, they believe that "traumatic experience is not inscribed within the psychic apparatus

and therefore cannot be associatively elaborated" (p. 497). But for my patient trauma was inscribed on the psychic register and submitted to various fantasy systems that fuelled his anxiety, depressive, suicidal, and psychotic symptoms emanating from his traumatic self-structure, which led to reality distortions based upon the indistinguishability of the present from the past. Hence the therapeutic obstacle was in the nature of representability that could not properly diffuse the anxiety attached to the memory. There was a fusion of the past memory with the immediate present experienced as an intensification and re-experiencing of traumas rather than simply remembering them devoid of the affective hyperarousal attached to the horrific contents, thereby lacking any clear temporal division between the present and the past, which in effect had become merged. Here it is important to make a distinction between the defensive or dissociative processes that protect the psyche from complete fragmentation or annihilation due to the invasiveness of trauma versus the notion that it is "not inscribed" within the psyche. Because the psyche is embodied, I do not make the ontological distinction between psyche and soma. The body-psyche or embodied-subject must be understood as a complex totality and not as a dualistic entity. It is for these reasons that, in my opinion, we should conceive of representation and the question of representability from within a monistic ontology that allows for different modifications of psychic activity.

In my clinical work with traumatised patients, I have made theoretical distinctions between (1) somatic schemata, which are embodied-sentient representational organisations; (2) affective schemata, which correspond to feelings and emotions; and (3) conceptual schemata, which describe higher mediated forms of symbolic, narrative, and associational processes of meaning derived from conscious and self-conscious life (Mills, 2005). Here mind must mediate trauma that is inscribed on the psychical apparatus by virtue of the unconscious agentic ego that directs defensive pathways towards finding suitable or adaptive internal constellations, which contain, protect, and insulate the self from annihilation. My argument is that trauma is mediated and represented in the mind but such processes are redistributed through desirous, somatic, perceptual, affective, and conceptual-symbolic forms of internal unconscious order. Of course sentient, somatic, and affective schemata are more basic and primitive, unsymbolised, prereflective, and unformulated, while conceptual and symbolic schemata are higher order semiotic and rational mediations that have undergone inner transformations in content and form.

This is why conceptual, narrative, and associational processing of traumatic details in the service of forming synthetic integrations and semiotic connections allow for more embodied forms of traumatic representations to sublate themselves in psychic structure and expression. When this occurs therapeutically, the patient can often make a transition from experiencing the somatic, physical, and emotional upheaval inherent within more constricted forms of traumatic representation, to finding new transformational achievements and psychic spacings that allow for higher-order meaning constructions and containment via speech and narration within the security, frame, discourse, and holding functions the analytic environment affords.

Because attachment is a central ontological process in personality development responsible for engendering certain forms of representation and symbolic functions, this process is mediated by the agency of the mother, which is the presentation of the original love object qua primary attachment figure who simultaneously communicates as an embodied linguistic subject within a cultural context. Language is a discernible part of the mother, but only after being differentiated out of the original unity of the infant–mother dyad (see also Loewald, 1978) once self and object representations take on modified aspects of representability. It is the discourse of the mother that initially informs unconscious structure and its corresponding representations, but this is still not a sufficient condition to account for psychic structure in its totality, as our instinctual embodiment, semiotic linkages, and psychological desires are also self-organised, not only within intrapsychic life, but within our cultural thrownness and historical contingencies that condition our social ontology.

Elsewhere I have shown how the epigenesis of the unconscious ego comes into being through trauma as a rupture from its primitive corporeal sentience, to the life of feeling, culminating in the ego of consciousness and self-conscious reflectivity (see Mills 2002a, 2002b, 2010). Here psychic structure is forged through conflict and negation as an architectonic developmental accomplishment. Mind is predicated on chaos, destruction, and death—the positive significance of the negative, which impels and fortifies psychic structure. Here Freud's views on the economics of the pulsions or *Triebe*, Lacan's emphasis on the symbolic, and contemporary attachment theory all potentially share common affinities.

While I have offered a conceptual argument that the psyche is originally constituted through trauma, and that the future experience of traumatising events in certain people with deficit self-structures would necessarily evoke earlier unsymbolised and complicated over-expressions of unresolved trauma, I can envision the possibility that even the healthiest people could develop psychotic symptoms regardless of their pre-existing psychic structure. What this ultimately means is that all human beings are predisposed a priori to develop psychotic organisations regardless of biological disposition or cultural circumstances: it simply becomes a matter of degree in their modes of concealment, containment, and manifestation. In short, we all harbour psychotic tendencies, whether realised or not.

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