TRAUMA AND PSYCHOSIS: A REVIEW AND FRAMEWORK FOR PSYCHOANALYTIC UNDERSTANDING.

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ABSTRACT

Empirical research substantiates Ferenczi's conception of the etiological importance of early neglect and abuse in the development of psychosis. Abuse can derail the development of language, identity, and social relationships that are intrinsic to schizophrenia, possibly through undermining secure attachment relationships. The Lacanian emphasis on language and early proto-dialogues with the Other can be useful in understanding this process. Some therapeutic implications for psychoanalytic approaches to the treatment of psychosis are proposed.

Key words: trauma, psychosis, symbolization, attachment

RESUMEN

La investigación empírica respalda la concepción de Ferenczi sobre la importancia etiológica del abandono y abuso temprano en el desarrollo de la psicosis. El abuso puede desviar el desarrollo del lenguaje, la identidad y las relaciones sociales que son intrínsecas a la esquizofrenia, posiblemente al socavar las relaciones de apego seguro. El énfasis lacaniano en el lenguaje y los proto-diálogos tempranos con el Otro puede ser útil para comprender este proceso. Se proponen algunas implicaciones terapéuticas para los enfoques psicoanalíticos en el tratamiento de la psicosis.

Palabras clave: trauma, psicosis, simbolización, apego

I begin with a vignette. Ms. C. is a paranoid schizophrenic woman in her 50s who lives alone on a retirement pension. She has never been hospitalized, nor has she taken antipsychotic medications. In her current life, she is quite isolated, believing that various family members are persecuting her, often in bizarre ways. For example, she believes that dead insects have been placed in her garage and that loud noises are transmitted through her walls to keep her awake. Although there are seemingly symbolic elements to her delusions, she has never shown the slightest interest in exploring them -especially as she does not see herself as ill. Although capable of speaking about her life in a rational manner, Ms. C. lives in a world of a dreamlike fusion of fantasy and fact in which perplexing events occur with great regularity -like objects mysteriously lost, appliance breakdowns, or missing computer files.

Ms. C. did not bring up the past spontaneously except as it touched on incomprehensible issues like the loss of a crucifix bequeathed to her by an aunt. Major events like her mother's suicide when she was a child, or her cousin's sudden death from meningitis shortly afterward, while they shared a bed, were not part of her ordinary discourse. Questions I raised about such serious matters were often followed by accounts of voices, strange coincidences, and angry outbursts at relatives. Nor was she interested in seeking explanations for her own sometimes provocative behavior, which was always rationalized. Although I was clearly an important person to her who could help her with practical issues, it was unclear why she continued coming to see me, although she did so with persistence. She denied illness and had never accepted medications. To be truthful, I found Ms. C.'s sessions tedious, and I found myself irritated by the litanies of imagined injustices. Why did she not speak about truly significant matters instead of what seemed trivial delusional events? Could her early traumas become part of our work?

Stories like Ms. C.'s are not unusual in the psychotherapy of schizophrenia, but what conclusions can be drawn from them? The question I raise in this paper is whether early childhood abuse represents an etiological factor in the development of psychosis. If so, should attention to trauma be a part of the treatment of psychotic patients? In his seminal paper, "Confusion of Tongues," Sándor Ferenczi (1949) noted that the importance of traumatic experience in etiology had been neglected and wrote of "the danger of resorting prematurely to explanations —often too facile explanations— in terms of 'disposition' and 'constitution'" (p. 225). Similarly, Winnicott (1975), who often inveighed against biological theories of mental disorders, wrote:

> It is not so well known (and indeed it is still a matter for proof) that disturbances which can be recognized and labeled as psychotic have their origin in distortions in emotional development arising before the child has clearly become a whole person capable of total relationships with whole persons. (p. 220)

Ferenczi hoped to pursue his hypothesis and, in a letter to Sigmund Freud dated June 29, 1930, wrote: "The finer mechanism of 'psychic trauma' and its relation to psychosis is also shaping up into a very impressive picture, at least for me." By a curious coincidence, Freud had written only months earlier to the author of a new edition of Shakespeare's King Lear: "As a matter of fact, I am not sure whether such hybrid formations of an affective clinging to a trauma and a psychotic turning away from it do not occur often enough in reality" (letter of March 30, 1930).

Unfortunately, psychiatrists and psychoanalysts for many years largely ignored the clinical insights of Ferenczi and Winnicott into the importance of early traumatic experiences. Freud's dynamic model of intrapsychic conflict and fantasy in neuroses dominated mainstream analytic thinking and, almost by definition, excluded psychoses from analytic treatment[1]. Meanwhile, psychiatric research emphasized genetic predisposition and a biological approach. In both cases, the specificity of traumatic experience was minimized as being of secondary importance (Read & Ross, 2003). In his harsh critique of psychoanalytic models of psychosis, Willick (2001) referred to "theory driven explanations unmodified by scientific investigation that have not stood the test of time and promoted useless treatments." His important debate with Robbins (1992, 2002) brought out the deep skepticism that psychoanalytic approaches had aroused, including the significance of early abuse as an etiological factor.

At the same time, the disappointing results of classical psychoanalysis and its disinterest in learning from research contributed to its progressive isolation from mainstream psychiatry. In 1998, the PORT consensus review, a policy paper on the treatment of schizophrenia sponsored by the US government, concluded (without much evidence) that family oriented treatments and psychoanalytic psychotherapy were contraindicated and harmful. Although subsequent PORT papers were supportive of "psychosocial" treatments, some of which incorporated psychodynamic concepts (e.g., Hogarty et al., 1997), psychoanalytic approaches remained absent from their recommendations (Tandon, Keshavan, & Nasrallah, 2008; although for dissenting voices, see Ver Eecke, 2003, and Karon, 2003). Important reviews on therapeutics in major psychiatric journals rely on randomized and controlled studies, ignoring, with rare exceptions (Mojtabai, Nicholson, & Carter, 1998), the psychodynamic literature. In a comprehensive metareview article of treatment studies of schizophrenia (Jääskeläinen et al., 2012), no improvements in outcome were found over recent decades.

A surprisingly high percentage of recovered patients have, however, been found in many samples, including untreated cases (see also McGlashan, 1988). On the one hand, this finding raises questions about reports of successfully treated patients in psychoanalytic therapies as perhaps merely reflecting the effects of as yet unknown healing processes in schizophrenic cases. On the other hand, the fairly stable proportion of positive outcomes suggests the value of exploring the nature of these processes in life or treatment, for example, involvement in a caring relationship.

Along the above lines, although psychoanalytic reports are often closely tied to highly abstract and debatable metapsychological concepts, it seems shortsighted to ignore the rich compilation of clinical observations they offer, which might point to areas for empirical study in psychotic subjects.[2] Moreover,

theory has value in providing hypotheses that can guide research. Unfortunately, the contemporary emphasis in psychotherapy research on the random assignment of patients to manualized treatments has until recently left little room for the study of psychoanalytically informed treatments (for all conditions). A few analytically oriented researchers have attempted to meet the stringent criteria of contemporary science, but mainly for neurotic and personality disorders, not for the treatment of psychosis (see Leichsenring & Rabung, 2008, for a comprehensive review).[3] This exclusion has left a gap in attending to the unique life histories of individual patients and their struggles to make subjective meaning of their disorders, areas where psychoanalytic approaches may prove most useful. For example, the study of cases showing a dramatic improvement after psychoanalytic treatment may identify important individual factors conducive to a therapeutic approach.

Certainly, most psychoanalysts, as Robbins (2002) has observed, accept the role of organic factors in psychotic conditions, but thanks to recent studies, we are now in a better position to integrate them with psychosocial variables. Notably, several empirical studies have made the role of trauma in psychosis no longer "a matter for proof," but a well-documented fact, with implications for treatment. In what follows, I will review this research, present some of the major currents in genetics and developmental neurogenesis as they bear on psychosis, and discuss possible mediators of the effects of traumatic experience, with clinical implications for a renewed psychoanalytic attention to the treatment of psychoses. I will then outline a specific model of traumatic etiology that has support from nonanalytic researchers.

Studies of Schizophrenia

Schizophrenia is known to be a highly heritable disorder, of course, although a significant proportion of the outcome variance in studies of twins (2040%), for example, is imputed to environmental factors (Kendler, 2001). In general, conclusions of genetic research on schizophrenia are contested in almost every respect, just as in most psychiatric research. Specific genes for schizophrenia have not been identified, and many geneticists no longer expect to find them (Crow, 1997).

Kendler (2000) has reviewed evidence for reciprocal influences of genes and types of child parent interaction (a genetic control of sensitivity to environmental factors or an environmental control of gene expression) that amply document the enormous complexity. For example, important adoption studies have demonstrated that family function influences the phenotypical expression of schizophrenia in adopted twins at high risk for becoming ill (Tienari et al., 2004a, 2004b). High scores for "critical/conflictual," "constricted," and "boundary problems" measures in families predicted negative outcomes for adopted children at high genetic risk. Similarly, Wahlberg et al. (1997) found that communication deviance in adoptive families predicted thought disorder in at risk subjects, while low levels of deviance were "protective" for the same children. Along the same lines, Swedish adoptees into families with a "disadvantaged socioeconomic position" had the highest risk for schizophrenia (Wicks, Hjern, & Dalman, 2010) (although adoptees with a family history of psychosis have a greater incidence of illness than subjects lacking this background). Lower socioeconomic status and being a child of migrants are also associated with schizophrenia (Tandor et al., 2008; Van Os et al., 2009). These findings attest to the significance of child-rearing and environment.

Childhood trauma, especially sexual trauma, but also physical abuse and neglect, has been known for some time to be significantly associated with adult psychopathology, even when other factors, such as family structure and parental illness, have been controlled for. This has been a consistent finding in twin research (Kendler, 2000; Nelson et al., 2002), studies of psychiatric patients (Perry, Roy, & Simon, 2004), and population surveys (Green et al., 2010). For patients reporting psychotic symptoms, data suggesting a "causal effect" of early trauma have been presented across many published studies (Larkin & Read, 2008; Read, van Os, Morrison, & Ross, 2005; Spence, Mulholland, Lynch, McHugh, Dempster, & Shannon, 2006; Varese et al., 2012). A critical analysis of these data by Morgan and Fisher (2007) qualified this conclusion, however, noting a lack of clarity of diagnosis, methodological problems in determining childhood abuse, and mixed results of studies. They also addressed the growing evidence for gene environment interactions across many domains.

Thus, considerable evidence suggests complex interactive effects between probable inherited susceptibilities and exposure to various environmental contingencies in life, including combat exposure (Lyons et al., 1993), trauma (Sartor et al., 2012), and response to "accidental" childhood events (Goodman, New, & Siever, 2004; Kendler, 2001). As a result, there has been a tendency for studies of environmental factors —for example, in the so called "stress-diathesis" model of schizophrenia— to emphasize their genetic determinants (Read & Ross, 2003) or biological effects (McGowan et al., 2009). Purely biological studies, in fact, dominate the research record.

In a large scale study of obstetric and developmental factors in New Zealand, for example, Cannon et al. (2002) found a correlation between adverse mother-child interactions and later schizophreniform outcomes. Mothers were rated on eight features: harshness toward the child; critical or negative evaluation of the child; rough, awkward handling of the child; lack of effort to help the child; unawareness or unresponsiveness to the child's needs; indifference to the child's performance; being demanding of the child's attention; and the soiled, unkempt appearance of the child —assessments found in previous research to be reliable and valid measures. The mothers of the schizophreniform group but not the manic group or the anxiety/depression group were significantly more likely to have "atypical" interactions compared to the mothers of controls. The authors concluded, however, that these findings were more likely to reflect the expression of schizophrenia susceptibility genes than the direct effects of childrearing, citing reports of early impairments among offspring at high genetic risk for schizophrenia. This emphasis is typical of papers supporting the stress diathesis model of schizophrenia (Read & Ross, 2003).

Heins et al. (2011) attempted to resolve some of these issues in a largescale study of 757 patients, their siblings and healthy comparison subjects controlled for levels of genetic liability, psychopathology, and type of trauma. Their data suggest that actual differential exposure to trauma "rather than reporting bias, reverse causality, or passive gene environment interactions" (p. 1286) is related to psychosis in a dose dependent manner. Although the nature of the abuse and its agent were not specified (details that might sharpen the findings), the results of this research support the significance of trauma itself as an independent variable significantly associated with later psychosis. An editorial accompanying this publication reinforced its importance while noting that how this association operates is left to be determined. "We need to explore why a proportion of individuals exposed to stress develops psychotic related outcomes," the editorial concludes (McGrath & Lawlor, 2011, p. 1236). Be that as it may, the use of the term "stress" to cover the sexual and physical abuse of young children perpetuates avoidance of the subject by psychiatry.

Many authors observe that underreporting of sexual and physical abuse is probable in research samples and that most cases remain unidentified by mental health staff (Read et al., 2005). Even if recall is found to be reliable (e.g., by using siblings as controls), detailed knowledge of the histories of schizophrenic families is lacking. For example, the identities of perpetrators and types of abuse are rarely specified. Robbins (2002) commented on the difficulty of eliciting meaningful developmental information outside a treatment relationship, and this must especially be the case with telephone and questionnaire type interviews.

From the perspective of several decades of inconclusive research, it begins to seem that schizophrenia itself may not be a specific disease with biological roots but a state of malfunction resulting from different kinds of interference with both brain maturation and psychosocial development.[4] In reality, of course, the two strands are the same thing, the pathways and centers of the brain developing in interaction with life experience, which for humans very importantly involves intersubjective relations, affective communications, and speech. In fact, it may be the very evolution of these human capacities for social cognition, self referential language, and mutual regulation that is the ultimate source of psychotic behavior.

The geneticist Crow (1997, 2007) has proposed that the origins of the psychoses involve those characteristics that are associated with the specifically human capacity for language. His theory identifies deviations of cortical development as results of a genetic change that led to the evolution of *Homo sapiens* as a species. Crow proposes that language and psychosis are often more closely related than is thought. The nuclear symptoms in particular, he writes, are clues to the structure of language, with symptoms arising as confusions between thought and speech and through the abnormal attachment of meaning to perceived

speech. Hence his comment: "Schizophrenia is the price that *Homo sapiens* pays for language" (1997). Support for a speciation hypothesis comes from the universal similarity of many features of psychoses, despite cultural differences in manifestation, the overlap of diagnostic features among mental disorders (see also Buckley, Miller, Lehrer, & Castle, 2009), and the prevalence of many symptoms in the general population (Bentall, 2003).

A recent editorial in the *British Journal of Psychiatry* (Kelleher, Jenner, & Cannon, 2010) comments on the finding that psychotic like symptoms of hallucinations and delusions are fairly common —about 10 times higher than the prevalence of actual disorders— especially in young people. The authors support the concept of schizophrenia as a disorder of social brain development, pointing to the importance of family therapy and social skills training in treatment. Van Os et al. (2009) also note the frequency of subclinical psychotic experiences in the general population and suggest that an accumulation of environmental risk interacting with nonspecific genetic factors produces these widespread phenomena. A recent study from Israel (Werbeloff et al., 2012) likewise found similar high percentages of frequent, although attenuated, psychotic symptoms in a large population survey. What is again lacking in these studies is attention to a history of abuse and deprivation as a major "environmental" factor in producing these developmental disturbances.

Development of Language, the Symbolic, and Attachment

To understand how trauma and neglect may result in schizophrenic disorders, we need to connect the typical deficits and symptoms of psychosis with developmental processes. The importance of access to language seems a promising avenue, as positive symptoms in schizophrenia are only identified and reported as speech or thoughts, and the ability to use relationships with others to modulate traumatic experience or to act as a barrier to it depends on the use of semiotic functions. Within psychoanalysis, Lacan was perhaps the most important theorist to hypothesize an inability to use language as the source of psychotic symptoms, notably as the basis for hallucinations and delusions, which are language-dependent entities (see Sauvagnat, 2003, and Vanheule, 2011, for discussions of this model). Of course, the concept of a thought disorder (in fact, a speech disorder) has been a basic feature of schizophrenia since Bleuler's work, and, recalling Crow's hypotheses, subjectivity depending on speech may be our key species characteristic, closely related to important developmental concepts such as theory of mind and intersubjectivity that have also been linked to schizophrenia (Lysaker, Outcault, & Ringer, 2010).

The specific deficit Lacan postulated in psychosis was an early failure to bind the primary experiences of bodily states and fantasies to the symbolic realm of language and culture (what he termed the real, imaginary, and symbolic registers). In brief, for the child to become a subject who can find its place in the social world, its physical states of arousal and accompanying mental imagery must be represented within the symbolic system of language that comes from the culture —in Lacanian terms, from "the Other." Lacan labeled the failure of this process as a "foreclosure" of what he called the paternal metaphor (referring to a third position outside the mother-child dyad). In simpler terms, mastery of language use and rules (Lacan's "symbolic order") is necessary to become a speaking subject in a social world. Lacan proposed that the developing subject seeks answers to inevitable questions about the meanings of life events, experiences with others, and personal identity by acquiring words and concepts from their milieu (Vanheule, 2011). Over time, a flexible symbolic identity grounded in speech supersedes earlier phases of self-definition through imaginary fantasies that revolve around dyadic relationships, such as early images of the mother that can invade or incorporate the subject (as presented in Kleinian theory).

When the child's development is characterized by a lack of access to an unavailable or rejecting Other, its capacity to employ language to define itself and understand its relationships to others is impaired. Concepts (metaphors) for common experiences important to the child may be lacking, and gaps can appear in the subject's subsequent attempts to articulate its internal states. Psychotic phenomena such as blocking, nonsensical associations, idiosyncratic messages, and neologisms represent failures to construct a coherent discourse. What cannot be symbolized or represented in speech can then appear to exist outside the subject,

in the real, as delusions or hallucinations, not as inner thoughts with personal meaning. The psychotic subject cannot use language effectively to express their place in the social order nor to grasp the reality of others. Instead, their fragile subjectivity is tied to frozen images involving one or two major relationships and a set of fantasies about them.

Lacan's position, like Winnicott's, implies a problem in the earliest mother-infant dialogue between the child and the Other (which can be defined as the field of language and culture represented by the mother), a process that has been linked to Bowlby's concept of attachment (see Fonagy & Target, 1996; Verhaeghe & Vanheule, 2005). This dialogue begins before the acquisition of language as such. In this regard, Allen (2004) has proposed the concept of attachment trauma to describe the disruption of a secure connection to the mother, which has been shown to impact the course of psychological, social, and neurological development, including language skills. These processes can be studied empirically using measures of attachment. For example, van IJzendoorn, Dijkstra, and Bus (1995), in a meta-analysis of published studies, reported a strong association between the quality of attachment between infant and parent and language development. Other research has linked insecure attachment directly to psychosis (Berry, Barrowclough, & Wearden, 2008; Read & Gumley, 2008).

From this perspective, early life trauma may produce its psychopathological effects by impeding or disrupting attachment links to the Other, especially when the perpetrator is a primary representative of symbolic authority, such as a parent or close relative, or part of a system of ideals and laws, like a policeman, teacher, or priest, all of whom can represent the Other for the child. A traumatic failure of the Other interferes with the child's ability to internalize culturally appropriate symbols and to learn ways to communicate their bodily and emotional experiences—to translate the bodily real into higher-level mental representations. Although secure attachment has been found to be protective against the effects of trauma (Aspelmeier & Smith, 2007; Kaplow et al., 2005; Saxe et al., 2005; Shapiro & Levendosky, 1999), severe trauma may overwhelm an existing secure attachment system, leading to the re-emergence of earlier forms of thinking based on fantasies about reality (i.e., non-mentalizing cognitions; Fonagy & Target, 2000). Posttraumatic stress disorder (PTSD) is a model for this relationship between trauma and a structural failure to symbolize or mentalize experience (Agius, Bradley, Ryan, & Zama, 2008).

In the varied clinical phenomena associated with PTSD, we see a range of individual susceptibilities and symptomatic responses to the overwhelming intensity of traumatic experience. Although there are important formal differences between schizophrenia and PTSD, in some patients psychotic-like symptoms complicate the diagnosis (Braakman, Kortmann, & van den Brink, 2009; Coentre & Power, 2011; Hamner et al., 2000). For example, one of the characteristic features of PTSD is a loss of a stable sense of self and connection to others, at times quite dramatic, a state also typical for psychotics. The inability to use language or to dwell in language, to use the Heideggerian expression, is also common in traumatized patients, who often have difficulty speaking about their histories to a therapist (Lysaker, Gumley, Brune, Vanheule, & Buck, 2011). Building a relationship with a traumatized psychotic patient may be even more challenging than working with a sufferer of severe PTSD. From this perspective, frank psychosis may lie on a continuum with PTSD as a disturbance in symbolic function resulting from the loss of secure attachment to the Other. Functional access to the symbolic (to the creative use of language to think and communicate) can be relatively tenuous for many people (perhaps traumatized people especially), who then employ language in idiosyncratic ways to deal with challenging circumstances. This seems a plausible explanation for the frequency of psychotic-like symptoms in the general population.

Treatment Issues

Research by Karon and Bos (cited in Ver Eecke, 2003) found that experienced clinicians were more successful with schizophrenic inpatients, especially over longer time periods. One explanation for this result may be the greater ability of experienced therapists to build a relationship with psychotic patients, which can take a long time. In general psychiatry, there is a growing recognition that individually designed approaches to treatment can be quite helpful (Mojtibai et al., 1998; Shean, 2009), suggesting the uniqueness of each

therapeutic couple's construction of basic communication links. The difficulty of building an alliance and trust with psychotic subjects has been emphasized by many psychoanalytic practitioners and suggests why the application of classic forms of analytic treatment may be misguided.

The focus of psychoanalysis on the individual subject, however, does provide the cornerstone of a psychotherapeutic approach, although the techniques of treatment may be far from traditional models (e.g., Abensour, 2008; Benedetti, 2011; Lucas, 2009). The psychotic is a person, a subject like anyone, but their subjectivity may take unusual and cryptic forms that can discourage clinicians from pursuing a treatment relationship. Lacan (1993) wrote in a late seminar about helping psychotics to ground their subjectivity through creative processes, making something new that establishes their identity through an object. In a similar approach, Abensour (2011) described how creative writing served as a kind of anchor in reality for many of her patients who suffered from the dilemma of a floating self, disconnected from the body, a past history, and relationships with others. Creative products acquire a real existence in time (like the transitional object) that can confirm the continuity of the subject and express its inner states.

Compared to targeted cognitive approaches, whose value is now better documented for psychotic patients, psychoanalytically derived therapies tend to work on more abstract goals such as supporting a fragile subjectivity, sustaining a relationship, and helping patients find ways to symbolize psychic distress through creative expression. Like more normal subjects, psychotic persons seek to find meaning for their lives and in their disorders (Read & Gilkie, 2009). Yet many schizophrenic patients, like other traumatized subjects, are only able to enter into this form of treatment after considerable preparatory work has been accomplished, and the meanings found are often quite private ones, as Lacan insisted (Sauvagnat, 2003). In this respect, psychoanalysts and cognitive clinicians may be at fault for not combining their experiences to build integrative models (Garrett, 2012) that might address the diversity of patients' needs. Such an approach would require different assumptions from those of a standard analytic treatment that relies on free association and interpretation of the unconscious.

Psychotic subjects cannot contain disruptive affects and memories by using words to communicate and construct meaning, and the emergence of these psychic elements can overwhelm their limited capacity for self-integration. Likewise, the transference to the analyst does not function in the same way as in neurotics to generate knowledge about the self (the analyst does not usually represent the symbolic Other as a source of knowledge and answers), but involves earlier developmental issues of holding, omnipotence, and continuity of being, as Winnicott (1960) stressed. Above all, finding vehicles for the expression of unspoken early trauma represents a major challenge for therapeutic efforts.

I return now to the story of my patient Ms. C. After a long time, having learned to abandon direct questions and interpretations about her early life and attempts to evaluate her delusional beliefs rationally, I began to allow the sessions to take a freer course. Responding to her expressed interest in artists, I learned that she was engaged in writing a children's book about an unusual Christmas ornament she had read about. As I became more open to listening to her discuss this project and eventually participating, I became acquainted with the characters of the other tree ornaments and their significance. Some analogies between Ms. C.'s story and her own life occurred to me, and, to my surprise, she joined me in clarifying some of the similarities and differences. In the process, she conveyed the nature of her childhood world —not only its traumas, about which I already knew some factual details from a relative— but also the lack of dialogic involvement with anyone (her solitude) and the secrecy with which matters of birth and death were treated by her relatives. No one ever spoke with her directly about her mother's disappearance, nor about her cousin's, for which she felt blamed or resented. Her current world of persecution now seemed merged with the actual circumstances of her past as a continuous expression of her unprocessed life experience.

At some point, I became aware that persecutory delusions and hallucinations had almost disappeared from the content of our sessions. We were beginning to develop a vocabulary to speak about a traumatic past.

CONCLUSIONS

In this paper, I have argued that past errors of psychoanalysis do not justify abandoning the psychotic to solely impersonal, biological approaches. Empirical research substantiates the importance of early family experience and abuse in derailing the development of self-identity and social relationships. The Lacanian emphasis on language and early proto-dialogues with the Other can be useful in understanding this process, which relates closely to difficulties in sustaining a secure attachment. Lack of secure attachment can impair the capacity to process trauma through speech and revive more primitive modes of processing experience. Attachment research indicates that the "finer mechanism" of trauma and "a psychotic turning away from it" that intrigued Sigmund Freud and Sándor Ferenczi is intimately bound up with a failure of the Other at crucial junctures, foreclosing access to symbolic representation. A renewed version of psychoanalytic treatment for psychotic disorders requires attention to the speaking subject's attempts to find meaning in the present through therapeutic dialogue, rather than seeking unconscious causes of symptoms or interpreting primitive transference meanings. The value of this approach may rest principally on its recognition of the singularity of the solutions each patient must create to survive as a subject and on the importance of the analyst's listening as they unfold.

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Notas al final

1.- Of course, psychoanalytic approaches to psychosis were pursued at places working in the interpersonal tradition, such as Chestnut Lodge Hospital, in Maryland, and in Kleinian centers. The results of this form of intensive treatment were disappointing. (McGlashan, 1988; Lucas, 2009). The International Society for Psychotherapy of Psychosis has represented analysts working in the area of psychosis for many years. Their contributions cannot be assessed in this article.
2.- See the rationale for exclusion in the 2003 PORT recommendations (Lehman et al., 2004).
3.- Karon's record of research is unusual in this respect, but it does not meet the criteria of groups like PORT for ''evidence-based'' treatment.
4.- Brentall (2003), a cognitive psychologist, has been a strong voice in questioning the categorical diagnosis of schizophrenia in favor of the effects of specific individual experiences.