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George B. Mitropoulos

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Complementary perspectives in subclinical psychosis: From clinical high-risk and personality organization to ordinary psychosis

George B. Mitropoulos

9th Department, Psychiatric Hospital of Attica, Athens, Greece

ABSTRACT

In this paper, I try to bring the Lacanian psychoanalytic concept of 'ordinary psychosis' (OP) into dialogue with the prevailing paradigms in psychiatry and psychodynamic theory regarding subclinical psychosis: respectively, the model of clinical-high-risk for psychosis and that of personality organization/disorder. OP is a bottom-up clinical approach applicable to both atypical/subclinical psychoses and disordered personality that identifies both the main psychological difficulties encountered and the compensatory mechanisms employed by the individual. Its diagnosis relies on subtle indices or markers of a 'disturbance of the sense of life' and of a failure of knotting together the elements of the subjective structure. Many patients typically diagnosed with a personality disorder may be treated as cases of OP. This clinical concept is not limited to a descriptive approach and it offers insights into both subtle psychological deficits and mechanisms contributing to resilience. It avoids the risk of unjustified preventive treatments and stigmatization carried by a model of attenuated psychosis. It facilitates the direction of the psychotherapeutic treatment offering more than support to the individual's adaptive attitudes. It offers insights into the communication between the medical and the psychodynamic models. OP is therefore a category of clinical utility, psychological validity, and ethical value.

CONTACT George B. Mitropoulos geobmitro@yahoo.gr

The author's affiliation has moved to private practice.
Among others, he has published the following psychiatric articles:

- Mitropoulos, G. B., et al. Psychosis and societal prescriptions of gender; a study of 174 inpatients. Psychosis, 2015, 7.4: 324–335.
- Mitropoulos, G. B. Auditory verbal hallucinations in psychosis: abnormal perceptions or symptoms of disordered thought? The Journal of Nervous and Mental Disease, 2020, 208.1: 81–84.
- Mitropoulos, G. B. The DSM-ICD diagnostic approach as an essential bridge between the patient and the 'big data'. Psychiatriki, 2018, 29.3: 249–256.

His research interests include psychoanalytic theory and practice, psychiatric diagno-sis and classification, clinical psychopathology, and the continuous dialogue among the various psychotherapeutic trends.

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Komplementäre Perspektiven in der subklinischen Psychose: von der klinischen Hochrisiko- und Persönlichkeitsorganisation zur gewöhnlichen Psychose?

ABSTRAKT

In diesem Beitrag versuche ich, das Lacan'sche psychoanalytische Konzept der "gewöhnlichen Psychose" (OP) in einen Dialog mit den vorherrschenden Paradigmen in der Psychiatrie und der psychodynamischen Theorie in Bezug auf subklinische Psychosen zu bringen: das Modell des klinisch-hohen Risikos für Psychosen und das der Persönlichkeitsorganisation/-störung.

OP ist ein klinischer Bottom-up-Ansatz, der sowohl auf atypische/subklinische Psychosen als auch auf Persönlichkeitsstörungen anwendbar ist und sowohl die wichtigsten psychischen Schwierigkeiten als auch die vom Individuum eingesetzten Kompensationsmechanismen identifiziert.

Seine Diagnose stützt sich auf subtile Indizien oder Marker für eine "Störung des Lebenssinns" und für ein Versagen beim Zusammenknüpfen der Elemente der subjektiven Struktur. Viele Patienten, bei denen typischerweise eine Persönlichkeitsstörung diagnostiziert wird, können als Fälle von OP behandelt werden.

Dieses klinische Konzept beschränkt sich nicht auf einen deskriptiven Ansatz und bietet Einblicke sowohl in subtile psychologische Defizite als auch in Mechanismen, die zur Resilienz beitragen. Es vermeidet das Risiko ungerechtfertigter präventiver Behandlungen und Stigmatisierungen, die von einem Modell der abgeschwächten Psychose getragen werden.

Es erleichtert die Ausrichtung der psychotherapeutischen Behandlung und bietet mehr als nur Unterstützung für die adaptiven Einstellungen des Einzelnen. Es bietet Einblicke in die Kommunikation zwischen dem medizinischen und dem psychodynamischen Modell. OP ist daher eine Kategorie des klinischen Nutzens, der psychologischen Validität und des ethischen Wertes.

Perspectivas complementarias en psicosis subclínica: de alto riesgo clínico y organización de la personalidad a psicosis ordinaria

RESUMEN

En este artículo, trato de poner en diálogo el concepto psicoanalítico Lacaniano de "psicosis ordinaria" (PO) con los paradigmas predominantes en psiquiatría y teoría psicodinámica con respecto a la psicosis subclínica: respectivamente, el modelo de alto riesgo clínico para psicosis y el de organización/trastorno de la personalidad. PO es un enfoque clínico ascendente aplicable tanto a las psicosis atípicas / subclínicas como a la personalidad desordenada que identifica tanto las principales dificultades psicológicas encontradas como los mecanismos compensatorios empleados por el individuo. Su diagnóstico se basa en índices sutiles o marcadores de una "perturbación del sentido de la vida" y de una falla en anudar los elementos de la estructura subjetiva. Muchos pacientes típicamente diagnosticados con un trastorno de personalidad pueden ser tratados como casos de PO. Este concepto clínico no se limita a un enfoque descriptivo y ofrece información sobre los déficits psicológicos sutiles y los mecanismos que contribuyen a la resiliencia. Evita el riesgo de tratamientos preventivos injustificados y la estigmatización que conlleva un modelo de psicosis atenuada. Facilita la dirección del tratamiento psicoterapéutico ofreciendo más que apoyo a las actitudes adaptativas del individuo. Ofrece información sobre la comunicación entre los modelos médicos y psicodinámicos. La PO es, por lo tanto, una categoría de utilidad clínica, validez psicológica y valor ético.

Prospettive complementari nelle psicosi subcliniche: dall'organizzazione clinica ad alto rischio e personalità alle psicosi ordinarie

RIASSUNTO

In questo articolo, cerco di portare il concetto psicoanalitico lacaniano di "psicosi ordinarie" (OP) in dialogo con i paradigmi prevalenti in psichiatria e nelle teorie psicodinamiche per quanto riguarda le psicosi subcliniche: rispettivamente, il modello di psicosi clinica-ad alto rischio e quello di organizzazione/disturbo della personalità. L'OP è un approccio clinico bottom-up applicabile sia alle psicosi atipiche/subcliniche che alla personalità disordinata che identifica sia le principali difficoltà psicologiche incontrate, sia i meccanismi compensativi impiegati dall'individuo. La sua diagnosi si basa su sottili indici o marcatori di un "disturbo del senso della vita" e di un fallimento nell'annodare insieme gli elementi della struttura soggettiva. Molti pazienti tipicamente diagnosticati con un disturbo di personalità possono essere trattati come casi di OP. Questo concetto clinico non si limita a un approccio descrittivo e offre approfondimenti sia sui sottili deficit psicologici che sui meccanismi che contribuiscono alla resilienza. Evita il rischio di trattamenti preventivi ingiustificati e di stigmatizzazione trasportati da un modello di psicosi attenuata. Facilita la direzione del trattamento psicoterapeutico offrendo qualcosa di più del semplice supporto agli atteggiamenti adattivi dell'individuo. Offre approfondimenti sulla comunicazione tra il modello medico e quello psicodinamico. L'OP è quindi una categoria di utilità clinica, validità psicologica e valore etico.

Συμπληρωματικές προσεγγίσεις στην υποκλινική ψύχωση: από την οργάνωση κλινικά υψηλής επικινδυνότητας και προσωπικότητας στην τυπική ψύχωση.

ΠΕΡΊΛΗΨΗ

Σε αυτό το άρθρο, προσπαθώ να φέρω τη Λακανική ψυχαναλυτική έννοια της «τυπικής ψύχωσης» (Ordinary Psychosis, OP) σε διάλογο με τα κυρίαρχα παραδείγματα στην ψυχιατρική και την ψυχοδυναμική θεωρία σχετικά με την υποκλινική ψύχωση: το μοντέλο κλινικά υψηλής επικινδυνότητας για την ψύχωση και αυτό της οργάνωσης/διαταραχής προσωπικότητας, αντίστοιχα. Το OP είναι είναι μια κλινική προσέγγιση από κάτω προς τα επάνω που εφαρμόζεται τόσο σε άτυπες/υποκλινικές ψυχώσεις όσο και σε διαταραχές προσωπικότητας, προσδιορίζοντας τόσο τις κύριες ψυχολογικές δυσκολίες που αντιμετωπίζει το άτομο όσο και τους αντισταθμιστικούς μηχανισμούς που χρησιμοποιεί. Η διάγνωσή του βασίζεται σε ανεπαίσθητους δείκτες «διαταραχής της αίσθησης της ζωής» και αποτυχίας σύνδεσης των στοιχείων της υποκειμενικής δομής. Πολλοί ασθενείς που συνήθως διαγιγνώσκονται με διαταραχή προσωπικότητας μπορεί να αντιμετωπίζονται ως περιπτώσεις OP. Αυτή η κλινική έννοια δεν περιορίζεται σε μια περιγραφική προσέγγιση και προσφέρει πληροφορίες τόσο για τα λεπτά ψυχολογικά ελλείμματα όσο και για τους μηχανισμούς που συμβάλλουν στην ανθεκτικότητα. Αποφεύγει τον κίνδυνο αδικαιολόγητων προληπτικών θεραπειών και στιγματισμού που φέρει ένα μοντέλο εξασθενημένης ψύχωσης. Διευκολύνει την κατεύθυνση της ψυχοθεραπευτικής θεραπείας προσφέροντας κάτι περισσότερο από υποστήριξη στις προσαρμοστικές στάσεις του ατόμου. Προσφέρει πληροφορίες για την επικοινωνία μεταξύ του ιατρικού και του ψυχοδυναμικού μοντέλου. Το OP είναι επομένως μια κατηγορία με κλινική χρησιμότητα, ψυχολογική εγκυρότητα και ηθική αξία.

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SCHLÜSSELWÖRTER subklinische Psychose; klinisches Hochrisiko; Persönlichkeitsstörung; gewöhnliche Psychose; Lacansche Psychoanalyse

PALABRAS CLAVE psicosis subclínica; clínica-alto riesgo; trastorno de la personalidad; psicosis ordinaria; psicoanálisis Lacaniano

PAROLE CHIAVE psicosi subclinica; alto rischio clinico; disturbo di personalità; psicosi ordinarie; psicoanalisi lacaniana

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Subclinical psychosis and disordered personality

The notion of subclinical psychosis is at least as old as Eugen Bleuler's work on schizophrenia. Bleuler was convinced that this condition cannot always be distinguished from normality or other types of mental illness. Bleuler claims that 'there are undoubtedly latent schizophrenias that never become manifest' (Bleuler, 1951/1951, p. 432). Such cases can frequently be met in

patients' relatives, in patients who complain of '"nervous" trouble', and in people who manifest 'schizoid peculiarities within normal limits' (pp. 433, 437). Ernst Kretschmer acknowledged his debt to Bleuler in discussing what he called the 'psychology of schizoids and schizothymes' (Kretschmer, 1925). His continuum model of psychosis included the notion of 'schizothymia' as a dimension of normal temperament between the extremes of schizoid personality and schizophrenia (Claridge, 2009). Kretschmer influenced the work of Hans Eysenck, who, in the 1950s, developed the concept of 'psychoticism' as a dimension of personality. Eysenck considered psychosis as a two-dimensional continuum consisting of a psychosis-normality and a schizophrenia-affective disorders axis. Eysenck saw no points of rarity on either of these axes, nor did he consider the category of psychosis to be qualitatively different from normality (Eysenck, 1992). His views, therefore, amount to a personality version of the *Einheitpsychose* view of psychosis, as well as a fully dimensional view of continuity (Claridge, 1994). In contrast, Paul Meehl's elaboration of 'schizotypy' (Meehl, 1962) amounts to a medical quasi-dimensional model where 'schizotaxia' corresponds to a schizophrenic spectrum and disordered personality is only an atypical form of disease (Claridge, 1994).

Recent research on the prevalence of psychotic experiences and symptoms in the general population has supported the quasi-dimensional model of continuity (half-normal rather than normal phenotypic distribution), offering substantial support to the view that psychosis can be seen as both a transdiagnostic and extended phenotype in the general population (Linscott & van Os, 2010; van Os & Reininghaus, 2016; van Os et al., 2009). Today, the discussion on subclinical psychosis and personality has crystallized into two distinct approaches that seem to have little common theoretical ground: on the one hand, the paradigm of clinical high-risk for psychosis and, on the other, the psychodynamic approach to personality organization.

The model of clinical high-risk for psychosis

Since the 1990s, research on sub-threshold psychosis has focused on the detection and early management of clinical states that are 'high-risk' for psychosis (CHR). Prediction and prevention of psychosis before the first manifestation and the development of significant disability have been pursued within the framework of interventions in help-seeking samples (Schultze-Lutter et al., 2015). Operationalized diagnosis of CHR generally relies on two discreet sets of descriptive diagnostic criteria. The 'ultra-high risk' (UHR) criteria, evaluate the presence of psychotic symptoms of attenuated intensity (APS), symptoms of brief or intermittent duration (BLIPS), and genetic risk plus

declined functioning (Fusar-Poli et al., 2013). A different set of criteria, the 'basic symptoms' (BS), focus on early cognitive impairment and perceptual disturbances and have been suggested to indicate an earlier risk stage than UHR criteria (Andreou & Borgwardt, 2020).

The CHR paradigm has been seriously questioned on account of several limitations. The current CHR prediction instruments have high sensitivity (96%) but low specificity (47%), and the validity of their application depends on clinical sample selection (Fusar-Poli et al., 2020). Despite the efforts made to operationalize the risk, it is estimated that less than 40% of the people who fulfill CHR criteria for psychosis will eventually develop a psychotic disorder (22% at 3 years) (Fusar-Poli et al., 2013). The estimation of this risk is also affected by the recruitment and selection of samples (Fusar-Poli et al., 2020). Conversely, it has been found that only 5–12% of first episodes of psychosis were detected at the time of their CHR stage, while the development of psychosis may not occur through a CHR stage in approximately one-third of first-episode cases (Fusar-Poli et al., 2020). Until now, evidence has proven no clear benefits of any available intervention over needs-based interventions (Fusar-Poli et al., 2020). Moreover, early interventions in CHR individuals 1) have been proven to reduce conversion rates only at short- to medium-term follow-up 2) have been less effective in youth samples 3) have failed to achieve significantly greater functional improvements (Schmidt et al., 2015). The CHR model has been further criticized for being 'blind' to multidimensional nonspecific psychopathology and 'seeing' only positive psychotic symptoms as precursors of transition to schizophrenia; also, the notion of transition remains uncertain (van Os & Guloksuz, 2017). This state of affairs has encouraged a yet unfruitful search for biomarkers that will supposedly complement clinical judgment and help predict the transition in CHR individuals (Andreou & Borgwardt, 2020). Ethical and legal concerns regarding the disclosure of a CHR diagnosis to patients and their families are no less important (Mittal et al., 2015). Despite the above limitations, the CHR paradigm has helped challenge 'the intrinsic pessimism' that has long inhibited preventive approaches in the field of psychosis (McGorry & Nelson, 2020).

Levels of personality organization in psychodynamic psychotherapy

A psychodynamic consensus has evolved that personality and personality syndromes exist on a continuum of severity which is divided into 'healthy', 'neurotic', 'borderline', and 'psychotic' levels of personality

organization (Kernberg & Caligor, 2005; Lingiardi & McWilliams, 2017). Patients not fulfilling diagnostic criteria for a psychotic disorder may nevertheless have symptoms of remarkable fixity and quasi-delusional proportions. Therefore, it may be psychotherapeutically useful to consider anorexic, extremely compulsive, somatizing, dissociative, or factitious patients (among others) as functioning in the psychotic range (Lingiardi & McWilliams, 2017). This model relies mainly on three psychological variables which underlie behavioral disturbances: degree of identity consolidation, matureness of defense mechanisms, and degree of reality testing. The 'normal-neurotic' level of personality organization is thus distinguished from the 'borderline-psychotic' by normal identity and the presence of mature defenses; identity diffusion and an absence of mature defenses are the latter's hallmarks. The degree of flexibility of defenses and coping strategies differentiates 'normal' personality, which is more flexible, from 'neurotic', which is more rigid. On the other hand, the 'psychotic' and 'borderline' levels of personality organization are less convincingly distinguished from each other: identity diffusion, absence of mature defenses, and deficits in reality testing are considered to be the psychological mechanisms in both levels (Kernberg & Caligor, 2005; Lingiardi & McWilliams, 2017). Even though a break with reality is accepted as a hallmark of psychosis, at the borderline level of severity reality testing is 'somewhat reduced, particularly in the setting of more intimate relations' (Kernberg & Caligor, 2005). Reality testing as a defining principle becomes even more precarious when we discover that even at the neurotic level of severity rigid defenses are likely to distort reality, albeit in one area (e.g. problems with authority) rather than globally (Lingiardi & McWilliams, 2017).

Kernberg and Caligor (2005) offer a schematic representation of the spectrum where all known types of personality disorder are conveniently accommodated in the area of high to low borderline organization. In contrast, the area of the psychotic level is curiously left devoid of all content. The authors claim that 'all patients with psychotic personality organization really represent atypical forms of psychosis', and, therefore, 'strictly speaking, psychotic personality organization represents an exclusion criterion for the personality disorders in the clinical setting' (pp. 134–135). This uncertainty regarding the nosological status of the atypical psychoses seems to exile them to a further borderline between 'borderline' severity and frank psychosis while failing to recognize the psychotic dimension inherent in many types of personality disorder, including 'borderline' (Yee et al., 2005). This intrinsic antinomy of the psychodynamic model illustrates that psychosis as a continuum with normality or as a clinical-high-risk state

cannot be effortlessly integrated with the paradigm of personality organization and disordered personality.

All the same, the psychodynamic approach is a welcome step towards addressing the continuity among normal and disordered personality and psychosis. In principle, psychodynamic treatment of personality disorders aims to change maladaptive and pathological character traits, modify internal object relations, improve the individual's representations of self and others, and decrease reliance on primitive defenses (Kernberg & Caligor, 2005).

I will now proceed to the discussion of the Lacanian psychoanalytic concept of ordinary psychosis, which is an alternative approach to the issue of subclinical psychosis.

Psychosis with and without psychosis: The psychoanalytical concept of ordinary psychosis

In his structural approach developed in the 1950s, French psychoanalyst Jacques Lacan made it conceivable that psychosis could be discernible in the absence of prominent psychotic symptoms. The internal logic of psychotic functioning was specifically elucidated as a *structure* distinguished from and opposed to neurosis. The primary structural defect in psychosis is theorized to be a symbolic 'hole', which is called the *foreclosure of the Name-of-the-Father*. This defect grossly corresponds to a non-consolidation of what Freud would call Oedipal prohibition. According to Lacan, 'this hole will give rise to a corresponding hole in the place of phallic signification' (Lacan, 2006, pp. 465–466). This latter term translates into what, in Freudian terms, we would call castration and denotes the essential acceptance of lack and deprivation into one's existence. Lacan described this logically second hole as 'a disturbance that occurs at the inmost juncture of the subject's sense of life' (Lacan, 2006, p. 466; Vanheule, 2020, p. 189). Therefore, this is a process of a fundamental symbolic defect leading to a defect in the subject's sense of life, that is, in any of the social, bodily, and subjective aspects of life, which is how Lacan astutely re-read the famous Freudian case-history of judge Daniel Paul Schreber (Hook, 2018; Lacan, 2006; Schreber, 2000).

Lacan's 1975–1976 Seminar, dedicated to James Joyce, marked a shift in his approach to psychosis. There, the standard Lacanian division of psychical reality into the Real, the Symbolic, and the Imaginary registers is redefined with the help of knot theory. What is now thought to support the subject is the mutual impact and intermingling among the three registers (Vanheule, 2011, p. 152). The paternal function (anyone of the possible Names-of-the-Father) is considered to be the essential term which secures that the three elements of the subjective structure are linked together as three mutually interlocked knots (a knotting which is called a Borromean link) (Vanheule,

2011, p. 161). Foreclosure is thereby conceived as a failure of the Borromean nodality of the structure of the subject while, at the same time, a repair of the knot is conceivable (Maleval, 2019, p. 38; Vanheule, 2011, pp. 156–157). Even though Lacan carefully avoided labeling Joyce as psychotic, he offered a detailed and very original account, first, of the very subtle, if obvious, traits that attest to his psychotic structure and, second, of the successful coping mechanisms which prevented Joyce from developing overt psychosis. Lacan thus paved the way for the elaboration of a notion of 'psychosis without psychosis' and an answer to the question he himself asked: 'was Joyce mad?' (Lacan, 2016).

In the years following Lacan's death, Lacanian psychoanalysis focused on the problem of 'mild psychoses'. In 1998, the term 'ordinary psychosis' (OP) was proposed by French psychoanalyst Jacques-Alain Miller for 'the psychosis that is compensated, supplemented, non-triggered, medicated, in therapy, in analysis' (Miller, 1999, p. 222). This approach considers the discontinuity between psychosis and neurosis as distinct structures and, at the same time, the continuity and importance of compensatory mechanisms, thus shifting away from a deficit model of either psychosis (Vanheule, 2011) or personality. OP is more of an epistemic than an objective category: 'Ordinary psychosis concerns your knowledge, your possibility of knowing something about the patient' (Miller, 2013, p. 149). It is a bottom-up approach to subclinical psychosis that aims to identify the main difficulties encountered as well as the compensatory mechanisms employed by the individual before using a top-down psychiatric label.

OP can be suspected when a neurotic structure cannot be supported (even though certain neurotic traits may be present) in the absence of evident clinical signs of psychosis. Diagnosis relies on subtle indices or markers of a 'disturbance of the sense of life' (Miller, 2013, p. 154), that is, of the failure of knotting together the three elements of the subjective structure (Maleval, 2019). Miller (2013) proposed that this disturbance may manifest itself in the guise of a triple externality: an individual may thus not be able to properly relate to his/her social role (e.g. disconnection from one's social function, over-intense positive social identifications, etc.), body (e.g. a lag in the relationship with one's body; artificial means such as piercing help one connect to one's body, etc.), and/or subjectivity (e.g. experience of void and emptiness, self-neglect, special relationship with language, miscellaneous identifications, etc.). Maleval (2019) proposed that these signs can alternatively be grouped according to the specific register they pertain to. A disconnection of the real is deduced by signs of non-separation from the drive object and of dysregulated jouissance (e.g. ecstatic phenomena, intense happiness, strange bodily sensations, hypochondriac concerns, urge to feminization, hoarding, etc.). A disconnection of the symbolic can translate into a lack of symbolic identifications and fundamental fantasy (possible signs:

lack of orientation in life, inconsistency of thought and purpose, discreet language disturbances and peculiarities, etc.). Finally, a slippage of the imaginary can be manifest as prevalence of imaginary identifications, sense of loss of identity, superficiality, inability to choose, dependence on others, etc. (also see Avdelidi, 2016, pp. 243–246).

Lacanian psychoanalytic diagnosis is binary and excludes the possibility of intermediate or borderline conditions between psychosis and neurosis. 'Borderline' cases are thus considered structurally psychotic (albeit ordinary). It has been shown that certain cases of perversion can be reclassified as cases of OP (Avdelidi, 2016, p. 258; Miller, 2022, p. 34). Miller (2013, p. 155) argues that, at any rate, OP should not be a 'refuge for not knowing'; once diagnosed, it should be classified in one of the classical nosological categories of paranoia, schizophrenia, or melancholia. Since psychotic symptoms are required to be absent OP should include only 'untriggered' psychoses or even perhaps cases that are 'unable to be triggered' (Avdelidi, 2016, pp. 256–257). J. D. Redmond (2013) favors an (unnecessarily) broader definition which also includes 'post-onset stabilized psychosis'.

Contrary to the CHR model which assesses the risk for transition based on symptom severity, the psychoanalytical assessment of the risk relies on the type of compensations used by the individual: elaborate compensations (like what Lacan in the case of Joyce calls a 'sinthome') tend to be more stable than compensations based on imaginary identifications (Maleval, 2000). Even then, however, the trace of the original defect is very likely to 'remain included within the solution' (Maleval, 2019, p. 45). Such subtle distinctions can be of great value for the direction of the psychotherapeutic process if not for a valid prediction.

A case study

Martin was 60 when he started psychoanalytic sessions on account of an 'inexplicable anxiety' and a 'sense of futility'. Anxiety has been with him since always; his birth was laborious, while a nearly fatal recent accident revived the question, 'why did I live'? Born to a wealthy family, he has always had to survive an 'overwhelming force': the dominant figure of his father, the perceived machinations of his mother, and death itself.

As a child, Martin had a phobia of snakes associated with a story told by his father: a memory from the latter's youth, a boa eating a live rabbit in a zoo. As a Scout, Martin learned how 'to be an observer, to keep at a distance, and remain cool'. Besides facing snakes, the very consistency of his ego would depend on this position of observer. Of all things observed, one image has been indelibly imprinted in his memory. He was 8 or 10: *'Sometimes, in the street, I saw a war invalid, without legs, crawling on the soil sitting on a tray with small wheels that served as a wheelchair. Whenever I saw*

him, I felt a tightness, a psychic pain. It was terrible. I tried to put myself in his place, I said to myself, "you are fine, the other is not".'

Martin, too, had lost something upon arrival in life: a partial hearing loss as a birth complication – but he was born rich. He has always felt ambivalent about his bourgeois class and, also, about his father, a self-made businessman, kind yet depressive, venerable, remote: 'an invisible power'. The origin of Martin's guilt towards the less privileged and its association with the signifier 'hubris' is located in his indelible image. To prevent nemesis, in his youth he actively worked with the Left and with severely ill children as a teacher. Being the 'observer', he helped others find solutions. He alone from his milieu 'let himself be touched' by the reality of misery, poverty, illness, even madness, often exceeding his limits and trying to transcend the fear of death. Yet, sometimes, exposure to the pain of others was beyond what he could endure.

Martin has never received a psychiatric diagnosis but sought psychological help in his early youth. The psychoanalytic sessions quickly soothed his anxiety, alleviated his extreme sense of duty, ameliorated his sleep, and generated a feeling of tranquility vividly expressed in dreams depicting serene landscapes. Yet, three years after the beginning of his treatment, dark moments still came out of the blue.

This is not a case of neurosis, because what organizes Martin's jouissance is not a phantasy with oedipal roots which could be constructed in analysis through the intermediary of a repressed phrase (Maleval, 2019, p. 141). Rather, it is an indelible image from his late childhood. In that image, a man has lost part of his body because of the violence of the Other; unlike the rabbit in the zoo, the man has survived that violence; it is a real castration of the body that cannot serve as a metaphor, that is poorly compensated and, as such, is made even more terrible by poverty and wretchedness. As in the Freudian case of Wolfman where a dream – fixity of the gaze of the wolves – is central, Martin's image is so important to him because it is an image of his very jouissance which functions as a protection from the drive (Cottet, 2017) and a window that frames a non-phallicized jouissance; in it, 'is situated the future of his mode of jouissance' (Maleval, 2019, p. 150): *'all my life I have been chasing after situations similar to it'*, Martin says regarding this image. Not being a neurotic phantasy that would entail separation from the drive object, it rather reveals a failure of repression (Maleval, 2019, p. 145). Consequent subjective solutions are socially appropriate but do not completely protect him from irruptions of the real, from anxiety and futility. We can construct this clinical case as a distancing from a privileged but problematic position and a return to it, but in new terms; a cyclical movement that is perpetual and repetitive; a solution that bears the traces of the

problem; a *sinthome* that permits the rectification of a situation presented in an indelible image, being at the same time a fixation to it and a repetition of a trauma. Martin's 'disturbance in the sense of life' manifests itself as a mainly subjective externality in the sense that he perceives his place in the world as problematic, which permits his classification as melancholic.

Martin's analyst is a partner of sorts who embodies no power or authority, yet demands engagement. Alternative, even witty, readings of Martin's blah-blah, the use of equivocation, punctuation, occasional cuts of the session, and the analyst's not unsympathetic stance appear to reward Martin's engagement, relativize his responsible-leader position and alleviate his agonizing sense of duty. Since the pandemic, Martin has turned to writing as a freelance contributor, a new version of the observer/leader with much less responsibility.

Discussion

The birth of psychiatry was necessitated by the problems posed by a single condition, that is, insanity (Shorter, 1997). As the discipline grew and discovered more and more conditions that deserved its attention, it was confronted with the infinite nuances and gradations that made insanity sometimes indistinguishable from reason and normality. To this problem, two very distinct approaches have been adopted so far: either subclinical psychoses are seen as high-risk conditions for the manifest syndrome, with all attempts being focused on preventing the transition to the latter; or the entire issue is expelled from medical nosology to the psychological realm of personality, with a superficial, if any, connection to the problematics of latent psychosis. These approaches seem to suffer from 1) an entrapment to a descriptive approach (attenuated forms of positive symptoms or personality traits), 2) a lack of theoretical understanding of what deeply distinguishes psychosis from non-psychosis, 3) neglect of the psychological mechanisms which contribute to the compensation of deficits, restitution, and eventually resilience. These problems are not unrelated to psychiatry's persistence with the a-theoretical descriptive model, which has prevailed since the 1980s. This model prioritized an exclusive reliance on more 'objective' and reliably defined symptoms such as hallucinations and delusions (Andreasen & Flaum, 1991), which became the target of the therapy, while at the same time making redundant the distinction between psychosis and neurosis (Beer, 1996). A further problem is that the medical and the psychodynamic models have little common theoretical ground, even though they regard largely overlapping populations.

For its part, Lacanian psychoanalysis never lost sight of the softer signs of psychosis which tend to be on a continuum with normality (Andreasen &

Flaum, 1991) and were not alien to, say, Bleuler; nor of what distinguishes psychosis from neurosis. In line with Lacan's later work, a psychoanalytic concept of ordinary psychosis has been developed during the last two decades (Avdelidi, 2016; Maleval, 2019; Peoc'h, 2022; J. Redmond, 2014; J. D. Redmond, 2013; Vanheule, 2018). Although psychiatry has generally neglected psychoanalytical approaches during the past decades, I believe that OP offers a potential answer to the pressing need for 'bottom-up, multimodal approaches that cut across categorical diagnoses and can help reconceptualize diagnostic classifications' (Andreou & Borgwardt, 2020).

The concept of OP stands beside the medical and psychodynamic models as an original contribution to the understanding and treatment of subclinical psychosis. It avoids the risk of 'false positives', unjustified preventive treatments, and stigmatization carried by a model of attenuated psychosis. Following the Lacanian analysis of the Joyce case, it treats the individual as an inventive subject with stabilizing and self-healing resources inherent in the psychotic structure; analytical treatment aims to precisely mobilize this potential (Maleval, 2019, p. 30). This is by no means simply an alternative treatment for non-analyzable patients and cases which appear to be 'complete chaos' (Kernberg & Caligor, 2005, p. 145). It does not amount to diluting the 'gold' of psychoanalysis with the 'copper' of supporting the individual's more adaptive solutions by means of cognitive and affective reinforcement (Kernberg, 2004, pp. 103–104). By distinguishing the tempering of unbridled jouissance from the analysis of the neurotic repression (Maleval, 2019, p. 17), it considers it possible 'to make a solution out of every symptom', while acknowledging that 'for any symptom there is a limited number of functions' which correspond to the finitude of the points of intersection of the Borromean structure (Peoc'h, 2022, p. 17). OP is therefore a category of clinical utility, psychological validity, and, also, of ethical value (Peoc'h, 2022, p. 15).

While the use of the term *ordinary* may help reduce the stigma carried by a diagnosis of psychosis, it may be conversely argued that the term *psychosis* might cause the same unnecessary stigma and worry to patients and their families as the disclosure of a CHR diagnosis (Mittal et al., 2015). I believe that psychoanalysis will not have a hard time discussing terminology issues; Maleval (2019, p. 200) has proposed the alternative term 'structure suppléante'.

In conclusion, I argue that the Lacanian psychoanalytic approach of OP can prove beneficial in many respects: it contributes to greater psychological validity distinguishing between psychosis as a transdiagnostic state or structure and psychosis as a clinical syndrome; it offers insight into findings such as those of Linscott and van Os (2010), according to which a psychotic spectrum exists which is far more widespread than clinical phenotypes; it deals with subclinical psychoses as situations deserving

a psychotherapeutic attention in their own right and not merely as risk states for more severe conditions; conversely, it does not consider subclinical psychoses as deficit states but rather as ones whereby the individual's psychological resources are recognized and exploited therapeutically; it enhances the dialogue between the medical and psychodynamic models offering a complementary unitary perspective to atypical, attenuated, or brief psychotic states; finally, it is in line with the expressed need for a psychologically detailed characterization of the individual case which would ideally focus 'on identity, meaning, and resilience' (Maj et al., 2021), and for providing help-seeking individuals with 'the *least onerous* feasible primary indicated prevention based on needs-based interventions and psychotherapy' (Fusar-Poli et al., 2020).

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No potential conflict of interest was reported by the authors.

Notes on contributor

George B. Mitropoulos, MD is a Psychiatrist and Psychoanalytic practitioner. He worked for two decades at the Psychiatric Hospital of Attica Dafni (Greece), the last two years of which as Consultant Psychiatrist and Head of Clinic. He has an immense experience with diagnosing and treating severe psychotic disorders. Since 2021 he works at his private office in Athens (6, Adonidos St, 14564, Greece) where he practices psychiatry, psychoanalysis, and psychotherapy. He is affiliated with the Borromean Knot Society of the New Lacanian School in Greece.

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