The Readiness is all ? Closure Remarks on the Psychotic Anticipatory Experience of Time and Space [1]

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Abstract
In this roundup paper we give an overview of the research we have done so far regarding the idea of anticipation and psychotic experience. Starting off from the status quaestionis in psychiatry, psychotherapy and philosophy regarding the psychotic experience as a disorder of reality we bring together three different viewpoints: the objectivist, the subjectivist and the existentialist. We illustrate how all three perspectives are unable to provide with a definite description of what psychosis really is, let alone prove fruitful for a causal model towards explaining psychosis. We show how the anticipatory model we have worked out (boundary, context, organisation, hierarchy) brings all three fields of enquiry together in a synergetic model with clinical, ethical and theoretical benefits.
Keywords: psychiatric status quaestionis, psychosis, modelling, diagnosis, therapy

"There's a special providence in the fall of a sparrow.
If it be now, 't is not to come,
if 't be not to come, it will be now;
If it be not now, yet it will come:
the readiness is all.
Since no man has aught of what he leaves,
what is 't to leave betimes"[2]
(Hamlet, act V, scene 2)

1 Introduction

In 1897 Freud wrote a letter to his erstwhile friend Fliess. "I vary Hamlet's words: 'To be in readiness' to be merry in everything. I could feel disconcerted about all this. The expectation of eternal glory en the accompanying wealth, the complete independence was such a great foresight, the travelling, to be able to liberate my children from the worries that have robbed me of my youth. All this depended on the question if [the theory of] hysteria was valid. Now I can remain still and modest, worry, save, and in this I come to a little story in my mind: 'Rebekka, take off your robe, you

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[2] http://www.playshakespeare.com/hamlet/scenes/146-act-v-scene-2

are not a bride anymore." (Freud, 1985*c*: 127; our translation) In this letter he readily admitted defeat. In this letter he stated that he could no longer believe his patients because of the continuing frustration of not achieving closure in the analytic cure, the fact that he could no longer assume that in the case of hysteria the father had always and factually abused their daughters, that in the unconscious no sign of reality is present which would allow to discern fact from fiction and lastly that in the case of psychosis no clue is to be found which undoubtedly hints at infantile trauma. (Geerardyn, 2002) Freud seemingly abandoned his first psychological meta theory (seduction theory) because he came to realize that his model of thinking got in the way of truly listening to his patients. (Ahbel-Rappe, 2006) So he started anew, not from scratch, but rising from the ashes of his first exercise in making sense of the undercurrents in the human condition.

Now 115 years later along the road, we are still stuck in the same rut as Freud. We do not have a consensus model that allows us to explain mental pathology. All efforts towards a causal model that is able to carry the load have shown to be in vain. Vanitas, vanitatum, omnia vanitas.

Especially in the case of psychosis this void stands out. The famous psychiatrist/philosopher Karl Jaspers considered the problem irrevocably unsolvable. (1913) We can understand psychosis (Verstehen), but we will never be able to explain it (Erklären) because we will never be able to know what it is like to be psychotic. (Ehrlich, 2008) A rift opens whenever we try to empathise with the psychotic patient in front of us. We will never be in readiness to overcome the schism in the contact.

Now what is psychosis according to Jaspers? It is as a false judgement, held with extraordinary conviction, impervious to other experiences and compelling counter-arguments, and with an impossible content. This basic definition holds to this very day. Gipps and Fulford (2004) demonstrate point for point that Jaspers held fast to a misleading definition of psychosis, which they name as *an estranged epistemology*. They propagate a different approach, *an engaged epistemology* where we take up an inner view of what it must be like to be psychotic. In focusing on the common ground of subjective suffering (complaint) the schism can be overcome. (Bentall, 2006) All it takes is a certain engaged anticipating readiness, a stance and approach which respects the psychotic subject as a person and not as a conglomerate of symptoms. The readiness means listening and receiving first, interpreting second.

To our opinion, this valiant effort is also misleading.[3] Because the key issue of psychosis is *the estrangement itself*, the loss of contact with a common sense idea/presentation/attitude towards reality, it is impossible to understand it as it unfolds. Even the psychotic subject is not capable of doing this in the acute phase of their psychotic episode. (Lezy, 2007) Only afterwards are they able to make sense of what they went through. They seem to be stuck in an endless and timeless experience of here and now without possible or at least stable reference to an experienced past or anticipated future. (De Grave, 2004; 2006; Parnas and Sass, 2002) For this reason, Wilfred Bion, a famous Anglo Indian analyst states that we should approach mental

[3] See further, existentialism

pathology without memory, desire or understanding, being in O. (1967; 1970) To be in readiness of treating psychosis, we should allow ourselves to open up the inner void each of us carries in the core of our being. To be ready to receive and treat is to loosen our own connection with the idea of this virtual reality.

In this enterprise the difference between psychosis, therapy and mysticism dissolves. We are no longer able to diagnose pathology from health, let alone make distinctions in different forms of psychopathology. The tension field between diagnosis and therapy pops up as poignantly as it disappeared in the mouth of madness. Who is mad and why? And who are we to judge? Tout le monde délire. Both the therapist as the patient are crazy, the only difference is that the patient was less fortunate in his or her walk of life.

Now we could say that this issue is merely philosophical/psychoanalytical and has no bearing on true scientific research and profound therapy. In this paper we will show that this is not the case. Our starting point will be the tension field between diagnosis and therapy, with three possible answers to seemingly do away with this pesky hindrance: objectivism, subjectivism and existentialism. These three –isms are extreme vantage points from where a myriad of problems have been dealt with throughout the history of human thinking. (Husserl, 1954) We could present them as points on a pendulum. In the case of questioning psychosis, the pivot and point of reference is reality.

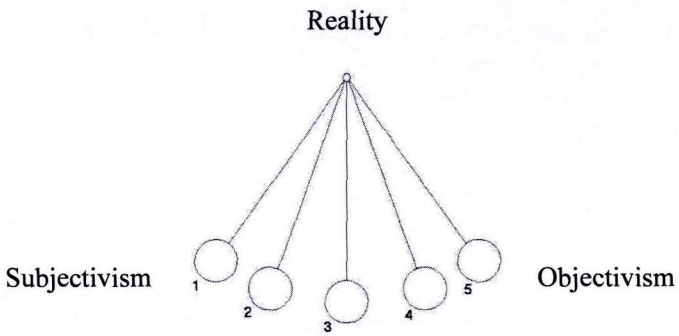

Figure 1: the -ism sling of reality

2 Three Vantage Points: Objectivism, Subjectivism, Existentialism

The three –isms can be considered as avenues of thought and conduct to try and understand psychosis. They are three forms of diagnosis. "Thus, diagnosis is the epistemological science of finding -or constructing- truth by distinguishing phenomena according to various categories and dimensions." (Wehowsky, 2000: 241) The base of an -ism is that the dividing line between truth (ontology) and knowledge (epistemology) becomes befuddled. What is portrayed, is seen as *the* truth and therefore puts this truthful knowledge on a par with other forms of untruthful knowledge. –Isms put up division and discord. As there can be ever so many forms of knowledge as there are

researchers, there can be only one truth, which is mine or ours. The question of right and wrong shifts into the zenith. (Gane, 2002) We are right, you are dead wrong. Enter the polemics. Let us break the different vantage points apart to get a clearer view.

2.1 Objectivism

Central to the objectivistic approach in psychiatry is the idea concerning *realism.* (Hoff, 2008) Finding the object which supports our scientific claims within a verified experimental set up proves that our knowledge is true. (Porter, 2002; Bentall, 2004) Truth and well managed knowledge run parallel, the trick is to find the bridges connecting the two. Objectivism is the story of the neutral outside observer looking in on the object to be studied.

2.1.1 Diagnosis → Therapy

Some people equal objectivism and reductionism. (Ssasz, 1974) This is a claim which does not hold. As we will come to see, both subjectivism and existentialism have reductionist properties. In objectivism, the reductionism only starts when the collection of raw data is processed and then presented as *self evident* in explaining the studied phenomenon. Objectivist reductionism using quantification for example is a powerful instrument, but fails as a means to build complex explanatory models.

Within psychiatry, Emil Kraepelin is the exemplum of objectivism and a portrayal of the benefits and dangers of this approach. (Bentall, 2004; deVries et al., 2008) He popularised the diagnosis *dementia praecox* for chronically psychotic vulnerable patients. (1899) They become demented early on in life because of the sickness process. (De Grave, 2013) The symptoms of the sickness are self evident in their explanatory nature: "Judging from our experience in internal medicine it is a fair assumption that similar disease processes will produce identical symptom pictures, identical pathological anatomy and an identical aetiology. If, therefore, we possessed a comprehensive knowledge of any of these three fields –pathological anatomy, symptomatology, or aetiology- we would at once have a uniform and standard classification of mental diseases. A similar comprehensive knowledge of either of the other two fields would give us not just as uniform and standard classifications, but *all of these classifications would exactly coincide*;" (Kraepelin, cited in: Bentall, 2004: 12) Kraepelin's research as a technical objective set up was beyond reproach, only his conclusions were fatally misled.

Encountering these symptoms in the standardised psychiatric research we are sure we can anticipate a mental and social decline in the patient's comport. (De Grave, 2013) We need no longer listen to the woes and the wants of the individual, our population findings prove that we are right in our claims. Moreover, if we really care for the specific needs of the subject, our neutral scientific vision gets clouded, so we would not advocate the best possible treatment as it was proven by scientific research. (Shorter, 1997) To help a sick patient, we have to distance ourselves from him and his chaotic mind and use our expert knowledge to cure him (prognosis and normalisation). Diagnosis in other words goes linea recta from the expert diagnostician into the heart

and soul of the observed patient. No matter what the patient says or does, our diagnostic assessment will bring the truth to the fore.

The most recent version of this objectivism in psychiatry is called Evidence Based Psychiatry (EBP), a subsection of Evidence Based Medicine (EBM). (Sackett, 1996; Sehon and Stanley, 2003) In the wake of the neo-positivistic tradition, supporters of this form of diagnosis proclaim that their evidence based approach, mediated by randomised control trials (RCT), prove that their form of advocated diagnoses and therapies are more effective and efficient than others. Their double blind research proves that the data found is self evident.

Central to this objectivist model is to do away with all subjective influences and biases, both in the therapist as in the patient. Diagnosis and therapy are value free, personal free, population based and symptom oriented. They describe and proscribe the best ways of diagnosing and therapy. The key issue is to be as objective as possible in the research, because subjective factors only mess things up. Although this model might work for other forms of treatment, in psychiatry it is beyond question that this method is biased, sometimes leading up to very dangerous conclusions. (Vandenberghe, 2008; Levine and Fink, 2008) For, when we anticipate certain insights stemming from our basic assumptions, we become blind to everything which does not fit in. We statistically do away with everything not fitting the model. Stating that this kind of research is the only kind of noteworthy research and that all the other forms are inferior, as propagated by the apostles of the Cochrane Collaboration, is opening the door to a very dangerous reductionism. (Holmes et al., 2006) Psychotic patients are seen as deviant, handicapped or abnormal and they have to be cured from this abnormality. Objectivists are not as objective as they proclaim, because they do not seem to notice their own subjective elements that motivate them in coming to their so called objective conclusions.

2.2 Subjectivism

Going against the grain of the objectivistic seemingly uncaring stance, we find the subjectivist response. These researchers for the most part claim that the source of mental pathology is not to be found on the inside of the subject, but that the disordering factors are for the main part *outside* the subject. A person is wholesome or at least true in and of itself and the problems lie outside (be it the family, society, psychiatry or the burdensome qualities of being in the societal world). Central to their idea is the idea of *socialism*. It is because of the social factors that the subject in question becomes ill and to treat the individual, we have to treat its environment, because we know that taking the subject seriously, we have to understand from the start that the subject is subjugated. Liberating the subject from the shackles of normality is the *Leitmotiv*.

2.2.1 Diagnosis ← Therapy

Foucault, Basaglia, Laing and Ssasz are the main exponents of this installation, under the umbrella term of anti psychiatry. (Rissmiller and Rissmiller, 2006) Foucault stated that: "In the serene world of mental illness, modern man no longer communicates with the madman: on one hand, the man of reason delegates the physician to madness,

thereby authorizing a relation only through the abstract universality of disease; on the other, the man of madness communicates with society only by the intermediary of an equally abstract reason which is order, physical and moral constraint, the anonymous pressure of the group, the requirements of conformity. As for a common language, there is no such thing; or rather, there is no such thing any longer; the constitution of madness as a mental illness, at the end of the eighteenth century, affords the evidence of a broken dialogue, posits the separation as already effected, and thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence." (Foucault, 1961 [2001]:xii)

Taking the mad seriously means offering him or her enough leeway to manoeuvre their lives to their own satisfaction. This led to two distinct translations in the emancipatory movement: *de-institutionalisation* and *institutional therapy*. The de-institutional approach is embodied by Basaglia (1964), the institutional therapeutic by Oury (Polack and Sabourin, 1976). Common ground for both is that the key problem lies outside the subject and treatment should be environmental. To cure the patient is to cure his or her surroundings, being society or the institution.

The main problem for the subjectivist stance is that we are no longer able or even allowed to come to a diagnosis. Laing, in his first work 'The divided self' (1960), stated that he had never met a psychotic individual because he did not consider them to be mad, judging from his own point of view. So, if we cannot identify any objectifiable criteria for psychosis, all stress twirls down to the subjective appraisal. Mad is he of she, I consider mad. Therapy becomes ubiquitous, diagnosis also. We anticipate not to be objective, so our judgment is militantly based on our own personal world view, delusional or not. Needless to say that this –ism does not respect the individual characteristics of the psychotic individual in and of itself. The *right to be mad* as an insurgence quickly transforms into a reductionist *obligation to be* mad. Seen as a (inter)subjective disorder (chaos or anarchy) rather than a sickness (abnormality or aberration), the subjectivist reductionism revolts against all forms of objective tendencies. Psychotics are seen as noble savages, true to the core of the chaotic nucleus that lives in everyman. Needless to say that this also is a way of not listening to the subject at hand, not being in readiness to receive his or her specific question.

2.3 Existentialism

The middle ground between the aforementioned extremes, we call existentialism. Going against Jaspers and his claim of un-understandability of psychosis and the psychotic experience, we find Binswanger (1965), Minkowski (1953), Blankenburg (1971), Conrad (1958) and Klosterkötter (1988), to name but a few. Coming from a phenomenological and hermeneutical background, these psychiatrists wanted to take the question of psychosis seriously. Their basic assumptions boil down to taking the psychotic experience seriously *as it is* experienced by the psychotic individual *him/herself*. The intentional description of what is must or might be like to be psychotic,

in close contact with the psychotic subject, provides us with the most accurate information of what psychosis might actually *be* like. (Lezy, 2007) The basis on which exchange happens within this approach is engagement.

2.3.1 Diagnosis ↔ Therapy

Between diagnosis and therapy, both the therapist and the patient intertwine in the process of communication. The patient is bent on the therapist, the therapist cares for the patient. In this mutual communication both subjects are enriched by the experience. Existentialists are on a quest to find the essential rather than the incidental features regarding psychosis.

The aforementioned phenomenological psychiatrists state that psychosis is a loss of the vital contact with reality, or as a *loss of the natural obvious*. (Blankenburg, 1971) This may come across as a mere combination of the objectivist and subjectivist approach. This is not the case: "Philosophical hard work is needed to avoid such abstract yet prevalent conceptions of our lived experience and to bring us back to the actual character of our everyday pre-reflective engagement with the world. (This conception of both the nature of philosophy and the nature of the mind is owed to the existential phenomenologists -especially Merleau-Ponty (1962).) In doing so we come to see how our understanding, manifest in our spontaneous interaction with the world itself, is not normally restricted to an inner realm but is only relegated there by an estranged epistemology. On the engaged perspective my having a mind is not in itself a matter of my possessing an inner realm with inner states and processes, although of course my capacity to think and feel and understand are underpinned by, amongst other things, the brain and neurological states and processes (cf. Bennett & Hacker, 2003, for a critical investigation of the ways in which a construal of the mind as 'inner' confounds neuropsychological theorising). Nor is it the best model of our comprehending engagement with the world provided by that of the detached contemplator. Rather, our mindedness is a matter of our being in certain relations with the world, and our understanding is first and foremost manifest not in reflection but in our experience itself. Perception is not a matter of sensory 'input' to an inner mind; rather it is a natural comprehending relation of people (and not of minds) to the world around them. Experience on this view is not typically a precursor of understanding, but itself one of the media of our comprehension." (Gipps and Fulford, 2004: 230)

The modern guise under which existentialism comes to the fore is called Value Based Practice, VBP. (Fulford, 2008) "(1) What kind of values or evaluations do we have to rely on to identify the class of mental disorder? For example, if mental disorders are by definition bad, then in what way are they bad? This question, which can be considered the central question of this paper, is based on the observation that there are many different types of evaluative considerations, e.g., that there are several ways in which a thing (event, or state of affairs) can be good or bad, e.g., morally, aesthetically, or prudentially (cf. von Wright 1963; Thomson 1992, 1994, 1996). (2) If attributions of mental disorder essentially involve values, is there any implicit reference to some specific evaluative standard? If so, whose standard? For example, if mental disorders are by definition bad, then according to whom are they bad? (3) If we assume that we

somehow have to rely on value judgments to specify the class of mental disorder, how exactly do these indispensable value judgments enter the picture? In what way is the concept of mental disorder (and the judgments that contain this concept) value laden? Or more specifically, is the concept value laden "in the ontological or definitional sense" or "in the epistemic sense" (cf. Wakefield 2000b, p. 254)?" (Brülde, 2007: 94)[4]

The existentialist conundrum leaves us with an unexpected cumbrance. Based on our truthful epistemic enquiry of the psychotic being in the world, how can we anticipate any ontological claims as to where these experiences stem from? The answer is that we cannot. We cannot judge if, when or why a certain intervention, attitude or criterium is or should be better than another intervention regarding psychosis. (Jackson and Fulford, 2003) The existentialist vantage point leaves us no measure to gain ground in solving the psychotic riddle, none more as the objectivist or the subjectivist inclination. Whether we choose one, two or three of these –isms seems to be a matter of taste. Or is it?

Central to the existentialist reductionism is the idea of *dis-ease*. Not to be at ease in the readiness of being in the world does not allow us to make judgments or differentiations in the mental dis-eases. Gestalt therapy as a precursor to the current therapeutic existentialism makes this clear by stating that diagnoses are of lesser worth because they hamper the process of coming to the wholesome Gestalt. (Perls, 1947) Looking honestly at psychotic suffering means to forcibly remain blind to certain key issues of the psychotic problem. Stating that we have to look for the values underlying mental disease leaves us no measure to make any state of the reasons for these ethical divergences. From an existentialist point of view, psychosis seems to be a matter of taste in our postmodern world of value free virtual consumption. (De Grave, 2009)

2.4 What Defies Definition: Reality

In constructing a new version of the psychiatric bible, the DSM 5 in 2013, the Dutch epidemiologist van Os, following Kapur, propagates eradicating the diagnosis

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[4] "That the concept of mental disorder is value laden in the ontological or definitional sense means that it is an evaluative concept, i.e. that it has evaluative content in a literal sense, that the "correct definition" of the concept contains an explicit value-component. If the concept of mental disorder is evaluative in this sense, then judgments about mental disorder are proper value judgments, and the truth or falsity of these judgments are (conceptually) "dependent of the values that influenced them" (cf. Wakefield 2000b, p. 265). That the concept of mental disorder is value laden in the epistemic sense simply means that the recognition of mental disorders relies on value judgments, i.e. that we cannot pick out the class of mental disorders without recourse to values. Once this distinction is made, it is rather obvious that a concept can be value laden in the epistemic sense without being value laden in the definitional sense. Suppose that we define "mental disorder" in terms of distress and disability, and that our reason for doing so is that we regard distress and disability as bad for the individual. If we assume that "distress" and "disability" are both descriptive terms, then the concept of mental disorder is not value laden in the definitional sense, i.e. it has no evaluative content. This would suggest that our disorder judgments are in principle factual, and that the truth or falsity of these judgments are really logically independent of the values that influenced them, i.e. the idea that distress and disability are bad for us. So the third question is really whether the concept of mental disorder is value laden in the ontological or definitional sense, or whether it is "merely" value laden in the epistemic sense." (Ibid.: 94-95)

schizophrenia altogether and replacing it with salience syndrome. (Kapur, 2005; van Os, 2009) This means that the psychotic intention to the world is not that different from normal human mentation, a salient variation of sorts. Furthermore, psychotic individuals are differently motivated to pick up the saliency of the inner and outer stimuli, which means they might be moderately eccentric in their being in the world, but not alien to it altogether. And lastly we could make a difference in this syndrome by identifying three subcategories: with a affective expression, with developmental expression and not otherwise specified.

We expect that the name change will not materialise in the DSM 5, because it means a radical change in approach. To stress the qualitative differences in saliency regarding the psychotic experiences is to make a statement about the readiness to take in new relevant information within a theoretical framework. In the paradigm shift of a new name and definition we hope to find a novel motivation which takes the psychotic experience and the person experiencing them seriously. In this endeavour, the differentiating and combining factors in psychosis as a sickness (biological) disease (psychological) and disorder (sociological) could be found. The question remains: what is the reality of psychosis? This hints at the question in full orchestration: what is reality? And why are certain aspects of this reality more succulent or appalling than others? And why are certain dull parts I consider of no appeal so salient to others whilst my fetishes and obsessions seem arbitrary to the outsiders? A very personal and intimate questioning, not for the faint of heart.

3 Psychosis as a Structured Form of Organisation : A Matter of Life and Death

In 1924 Freud published two peculiar texts in the wake of his book 'The Ego and the Id', presenting his second topology (Id-Ego-Superego). In 'Neurosis and psychosis' and 'Loss of reality in Neurosis and Psychosis' he demonstrated in just 12 pages that the difference between neurosis (normality) and psychosis is not based on hallucinations or delusions, but on saliency. (De Grave, 2013) Neurotic and psychotic subjects are differently nested in the experience of reality. (De Grave, 2006; 2008; 2009; 2013) In continental psychoanalysis we speak of three kinds of human mental organisation: the *neurotic*, the *psychotic* and the *perverse* structure. (Verhaeghe, 2008) These three are ever so many ways of approaching reality. In neurosis the painful elements of reality are suppressed (Verdrängung), in perversion they are disavowed (Verleugnung) and in psychosis they are rejected (Verwerfung). These three defense mechanisms are three modes of coming to grips with the (albeit wonderful, dull or painful) saliency of reality.

Now what are the salient features of reality par excellence? Four years before Freud had written his most controversial and convoluted text, 'Beyond the Pleasure Principle' (1920g). In this he discovered that human kind is motivated by two drives in juxtaposition, a life drive (*eros*) and a death drive (*thanatos*). We will not delve in the intricacies and fallacies of this discussion as it will lead us too far off track. (De Grave, 2001a; 2001b) We will only mention the work of the Ghentian philosopher Boullart in this matter.

He suggested the *conditions of detrivialisation.* "Everything that is, that is thinkable, has to be finite and the basic conditions of this finiteness are the only possible, necessary and sufficient conditions under which all nonsensicality can de iure and de facto be defended against or warded off. Every one who does not allow the necessity of these 'conditions of detrivialisation', wherein our finiteness is uniquely and canonically affirmed and acknowledged, that person has devoted himself to madness and its presumptions. [...] The one who is aware that he is born, that he lives and that he will die, does not have to outspoken pessimistic or over enthusiastic to acknowledge that the world we live in can be described as stated." (Boullart, 1999: 224-225; our translation) You are born, you live, you are going to die. Nothing more than these three matters of fact can be made out on an existential level. The Conatus as an inclination of a thing to continue or enhance itself (Traupman, 1966: 51) is omnipresent in all conscious and unconscious levels of human existence. And, as far as we can gather, we as human beings are the only creatures consciously aware of this necessary demise. (De Grave, 2004) Although a lot of therapists recognise that the bulk of the delusions deal with exactly this existential puzzle, few have been inclined to work out a solid theory based on these foundations. (Matte Blanco, 2005)

4 The Psychotic Problem According to Lacan: Forclusion and RSI

In reworking the Freudian theory, the French analyst Jacques Lacan took up the glove. He had a lot more clinical experience than Freud in the field of psychosis and in holding fast to the guiding principle of reworking the theory based on clinical journeys, he constructed 4 new models by which to interpret the psychotic process. (Fellahian, 2005):

- The personality model (1932)
- The family complex model (1938)
- The foreclusion model (1955-1958)
- The borromean model (1974-1976)

Due to space limitations we will only pick up the last two.

Foreclosure is a legal term referring to the process of recompensation where the lender is allowed recompensation of a mortgage if the borrower cannot meet the agreed upon arrangements. Usually the foreclosure is dealt with in a court room. Lacan picked up this idea of foreclosure when he wanted to discuss the preliminary question to any possible form of treatment regarding psychosis. (1959 [2002]) He selected the Freudian idea of Verwerfung and translated it in the familial context. (Maleval, 2000)

The foreclosure focused mainly on *The Name of The Father.* By this theoretical excursion based on the case report of judge Daniel Paul Schreber he wanted to demonstrate *how* a psychotic subject becomes disconnected to reality. He did acknowledge that a certain psychotic *disposition* may be present, even necessary to come to the psychotic form of organisation. (1955-1956 [1993]; De Grave, 2013) The key issue he stressed that this form of organisation could be differentiated from the neurotic and the perverse, based on a *solid point of comparison.* In the speech and the comport of the patient during treatment, these signs are noticeable and point in the

direction of the underlying structure. To make this distinction is relevant because what works in the therapeutic contact in one structure (interpretation, confrontation, therapeutic abstinence, free association,...) may be harmful even damaging in another. Diagnosis can be seen as a warning sign for the transference aspects in both the patient and the therapist, a supporting measure for receiving and treating the patient. In this way, Lacan and Bion come very close together as the approach in the therapeutic readiness is seen as the key to transformation. (Bion, 1970; Lacan, 1959 [2002])

20 years further along the line Lacan in his seminar transformed his forclusion model to the *borromean RSI model.* (1975-1976 [2005]) Working on the oeuvre of James Joyce and asking the question if he was mad, he tried to understand the possible psychotic undercurrents in Joyce's writings and wondered if and how his writing had worked to stabilise the psychotic elements. Through his work as an artist, Joyce was able to be in another kind of readiness to keep the anticipated chaos of psychosis at bay (sinthome).

This lead to a novel approach of looking at reality. To Lacan the fabric of reality exists on three levels (Real-Imaginary-Symbolic) which are knotted together to form the whole of existential experience. (Lacan, 1974-1975) In this knotting and unknotting of RSI, the Freudian metapsychology Eros Thanatos was included in the model. (Lacan, 1973-1974; De Grave, 2001a) This construction allowed both Lacan and his followers to rethink both diagnosis and treatment for psychosis, paving the way towards a new form of psychoanalytical therapy Freud had dreamt off in 1924.

Central in this approach is that the real, the imaginary and the symbolic are not so tightly intertwined in psychosis, so they can break apart when confronted with a breach in the drive economics (Physical, mental, social, sexual trauma). This triggering off (déclenchement) is akin to the idea of aforementioned foreclosure. (Stevens, 2002)To reknot RSI the patient and the therapist jointly search for a supplement to reknot.

This is called suppletion[5], the installation of a fourth ring (a sinthome) which binds together. It is in the therapeutical contact that this suppletion takes shape. Both partners have to be in readiness for this process in order to have any chance of success. This meeting ground is called transfert where the transformations in O become intertwined. (Bion, 1970)

5 The way Forward: Eclecticism and Synergy

And so we come to the round up, mustering all the strengths and weaknesses out of what we have discussed so far. Approaching the problem of psychosis we found four perspectives, each with its benefits and shortcomings. The difficulty lies in the fact that each perspective clings to their objective for dear life and vehemently tries to convince us that only their perspective is true to the cause. Needless to say, this reductionist train

[5] In linguistics and etymology, suppletion is traditionally understood as the use of one word as the inflected form (modification) of another word when the two words are not cognate (do not have the same etymological origin). For those learning a language, suppletive forms will be seen as "irregular" or even "highly irregular". The term "suppletion" implies that a gap in the paradigm was filled by a form "supplied" by a different paradigm. (from suppletion in wikipedia - the free encyclopedia).

of thinking is pointless and even derails dangerously when put to the extreme. It is not in the interest of the patient if they wrestle over their problems just to prove they are right and the others are wrong. Fighting and bickering means *not* listening to the patient, means leaving the readiness to receive behind. We do not have to listen to the patient anymore, because we already know what they will say.

The alternative to this splintering reductionism is *non reductionism* or *complexity*. (De Grave, 2008) Non reductionism does not equal holism as in solving or pacifying the tension between the extremes of the system. As a conflict model, non reductionism makes use of the differences and tensions to reach a higher level of complex interpretation and possibilities just like any other complex system. (De Grave, 2001b) Without the tensions, the system is dead, rigid and stale. It means that none of the reductionist views holds the key in itself, only through a complex interaction of the tensions between the four fields can we achieve success.

Abandoning reductionist eclecticism would be a step in the right direction.

The current domain of looking at psychosis is nevertheless rife with this eclecticism. Taking up bits and pieces of different theoretical models, throwing them in a big stew without a good cook book is unpalatable to at least our taste. One problem is that reductionist models cannot simply be mixed with other reductionist models in the hopes of making it *less* reductionist. This just calls for bad reductionism. Because of this blind spot or pitfall we advocate *xenogamy* as a form of complex synergy, where the different components of a system working together obtain a result not independently achievable. For this synergy to work, we need a different kind of readiness as a fertile ground of (de)constructive collaboration.

In other publications and lectures we have put a model forward that is applicable to synergy. It is based on four fundamental concepts to any possible theory of complexity: Boundary, Context, Organisation and Dynamic hierarchy.(De Grave, 2001b; 2008) Using these four concepts as possible, necessary and sufficient components of a complex model to come closer to the psychotic problem, we hope to build a consensus idiom where the –isms can come home to roost. The common ground for this model are the conditions of detrivialisation, meaning that our research object, the psychotic subject, is as mortal as we are and struggling with this awareness without the possibility of ever overcoming it. Questioning the vestiges of psychosis means questioning ourselves, our very own fears, frustrations, doubts, wants and woes.

6 Conclusion and in Closure: a New Beginning

So, the main problem of psychosis according to us points in the direction of the main question of philosophy: what is it like to be a mortal human being? And therefore we will make a bold gesture and define psychosis: *Psychosis is a different form of directness*. What form? What direction? What difference? It pertains to mortality and coming to grips with the reality of being born, living and certainty of death. The existential questions we as human beings can have are related to the experience of Sein zum Tode, being for death (Heidegger, 1927). To be in readiness to earnestly study psychosis is to allow ourselves the problematic leisure of not knowing what is going on

but to share our limited perspectives to come to a deeper, more profound questioning of the truth. Psychotic subjects are not merely diseased, sick or disordered. They are *different* and respectfully studying, explaining and supporting these likenesses and differences should be the main goal. To be in readiness means not knowing but wanting to understand, time and again.

To be, or not to be: that is the question:
Whether 'tis nobler in the mind to suffer
The slings and arrows of outrageous fortune,
Or to take arms against a sea of troubles,
And by opposing end them? To die: to sleep;
No more; and by a sleep to say we end
The heart-ache and the thousand natural shocks
That flesh is heir to, 'tis a consummation
Devoutly to be wish'd. To die, to sleep;
To sleep: perchance to dream: ay, there's the rub;
For in that sleep of death what dreams may come
(Hamlet Act III, scene 1)[6]

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[6] http://www.playshakespeare.com/hamlet/scenes/134-act-iii-scene-1

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