Time is of the Essence: the Importance of Anticipation in the Treatment of Schizophrenia

Dieter De Grave [1]
Psychiatric Center Duffel, Stationsstraat 22c, B-2570 Duffel
0032 +15304954 - Dieter.de.grave@emmaus.be
University Ghent (Faculty of Philosophy), Blandijnberg 2, B-9000 Ghent
Dieter.degrave@ugent.be

Abstract
In the treatment of schizophrenia we can observe a certain inclination towards anticipatory theories and methods. Especially in the areas of prevention and early detection we see this development taking shape. What is mostly lacking in this novel approach is the idea that anticipation is deeply nested in every living system, even a pathological one. The dynamics of the process change during the course of observation and make meaningful predictions more difficult. So it is of the utmost importance to analyze the field of emergence which is schizophrenia as a plain of divisions, schisms and faulty recombinations, embedded from the start. The time(observer) approach in the therapeutic setting from a subjective point of view offers a way to approach and understand the tension that exists in the developmental lines within schizophrenia (pathological, ordinal, original, transcendental). We demonstrate this problem using the technique of lichaamskaart in the therapeutic time perspective.
Keywords: schizophrenia, anticipation, pathology, lichaamskaart, therapy

1 Introduction

Time is of the essence:
"Contractual provision that requires prompt and timely fulfillment of obligations under the contract; failure to complete performance under time constraints set forth in the document may constitute a breach."

Schizophrenia and psychosis deserve attention from a complex anticipatory point of view, but time is of the essence concerning diagnosis and therapy in this matter. Schizophrenia is usually seen as the global functional brain disease with vast economic, medical and social implications, both for the sufferer as for his or her environment.[2]

All the papers we have presented for this audience thus far are infused with a certain inclination: to critique the reductionist view of mental functioning and to demonstrate that complex non reductionist views offer better alternatives to approach the problem of psychosis. (De Grave, 2004; 2006; 2009)The main problem we will try to tackle in this

[1] This paper was made possible by a grant from the Fund for Scientific Research (FWO)
[2] http://www.nimh.nih.gov/health/publications/schizophrenia/what-is-schizophrenia.shtml

contribution concerns treatment: knowing *when* to intervene and *how* to intervene? In 2011, a lot of attention is put in early detection and prevention of psychosis and schizophrenia, both on a national and an international level. We mention three: Genetics research, the construction of the DSM 5[3] as a new diagnostic tool and the VDIP[4] (Early Detection and Intervention in Psychosis) initiative. But the questions remain: *How are we going to treat what has not yet come to be?* Is psychosis embedded in the personal system from the start? Does it lie there like a slumbering inner demon, waiting for the wake up call to wreak its havoc? And if so, how are we going to prove this and if possible prevent this dire outcome? Understanding schizophrenia as a mental disease or as a form of complex organisation means looking at what holds and what divides. (De Grave, 2013) Time is of the essence because a certain direction in the inquiries has to be found now that new opportunities and fallacies move to the frontline.

From the philosophical point of view we gather three fields where a dividing line runs through the history of our Western thinking since Plato: Time and Space (Plato), Form and Content (Aristotle) and Body and Mind (Descartes). Of course you can state that we as postmodern creatures have moved beyond this reductionist dualism. A clear and realistic view at our current scientific mainstream shows that this is not the case. (Holmes et al, 2006) The reductionist dividing perspective remains the core of our limited observer view point. Notwithstanding the valiant phenomenological, hermeneutical and psychoanalytical efforts the reductionist approach is overpowering and all encompassing in the scientific approach to the psychotic problem. (De Grave, 2013)

We will focus on three main problems in the treatment of psychosis:

-Heredity of schizophrenia (anticipation)

-Implicit theoretical and therapeutical undercurrents (theoretical background)

-Application of these in the technique called *lichaamskaart* (psychodynamics)

2 Heredity and Anticipation: Objective Symptoms and Degeneration

Past and current research in schizophrenia shows that it is 50% heritable 50% environmental. (Tsuang et al, 2001) Some researchers go as far as 70 to 90% heritability. (Maletic, 2011) These studies focused first on monozygotic and dizygotic twin studies, family studies and later on they tried to study core genetic molecular research. (Green, 2001) Seven or more genes are identified as possible markers of the schizophrenic vulnerability. (neuregulin, dysbindin, COMT, DISC1, RGS4, GRM3 and G72) It is important to mention that these genes and other suspect genes are also identified in a myriad number of other mental and neurological illnesses: major depression, bipolar disease, autism and Huntington's disease to name but a few.[5]

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[3] http://www.dsm5.org

[4] http://www.vdip.be

[5] "A recent study by molecular biologists at UC Irvine isolated a gene, hSKCa3 located on 22q, which leads to an increased risk to schizophrenia. Previous studies have shown this region to be a likely candidate for genes involved with schizophrenia. hSKCa3 codes for an potassium ion channel and acts to dampen the electrical activity and as an "off switch" to signals that are triggered by the NMDA

2.1 History and Current Views

The idea that insanity is hereditary is not new, it predates the use of the diagnosis schizophrenia itself. (Shorter, 1997: 105) In 1857 Morel wrote a monograph about this degeneracy "démence précoce". He found in that in families where psychiatric symptoms are rampant, the symptoms worsen through the generations, and that the moment of onset takes hold earlier in subsequent generations. Example: where the grandmother suffered from depression and the grandfather from alcoholism, the father suffered manic episodes, the mother from hysteria, then the children were afflicted with mental debility and full blown incurable psychosis. These ideas in the second half of the 19th century found their culmination in the work of the first scientifically oriented psychiatrist, Emil Kraepelin. "The doctor's first task at the bedside is being able to form a judgment about the probable further course of the case. People always ask him this. The value of a diagnosis for the practical activity of the psychiatrist consists of letting him give a reliable look at the future." (Kraepelin, 1899, cited in Shorter, 1997: 106-107). Investigating the idea of psychosis in a familial framework, he popularised a term for these degenerates, namely *dementia praecox*. Bluntly stated, these patients became demented early on in their life and as such could never prove fruitful contributors to society (Verblödung, Schwachsinn or Defekt). Although Kraepelin himself had clear Nationalistic tendencies, we cannot blame him for the way the nazis picked up his ideas for the prohibition on procreation, forced sterilization and eradication of mental patients. (Shepherd, 1995; Bentall, 2004; Hoff, 2012) He died in 1926. But it stands out as a warning sign that ideas about the hereditary aspects of schizophrenia should be treated with the utmost care given the political, scientific and cultural climate in which they are put forward. Eugen Bleuler, the namegiver of the diagnosis schizophrenia, critiqued his mentor on exactly these two points. (Kaplan, 2008) In *Die prognose der Dementia Praecox (Schizophreniegruppe)* (1908) he stated that the psychotic patients he saw did not all progressively worsen throughout their life span and the disease did not always strike at an early age. (Blom, 2007) He *did* hold fast to the idea that psychotic patients were handicapped more or less (the two central symptoms according to him were Assoziationlockerung and Benommenheitszustande), but he considered that psychological and social treatment with these patients would prove fruitful. (Bleuler, 1911) The ambivalent influence of psychoanalysis through his pupil Jung and his correspondence with Freud is clear in this matter. (Jung and Bleuler, 1908; Falzeder, 2007) He proposed to use the term Divided Mind (schizophrenia) because he thought that the psychotic problem was one of the problems in the relational context. He saw

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receptors. In addition, the isolated gene also contains a characteristic CAG repeat like the defective huntingin gene that leads to Huntingtons disease. Similar to Huntingtons disease, this poly tri-nucleotide repeat may also lead to anticipation, in which subsequent generations accumulate CAG repeats; this increased poly-glutamine stretch is correlated to earlier onset and worsened states of the disease." (http://www.schizophrenia.com/research/hereditygen.htm)

that psychotic patients had internal problems with combining diverse faculties in their global functioning. (Association) Moreover, for him as a psychiatrist it was very difficult to come into contact with the inner world of these patients. It was as if schisms were to be noticed, both within the patient and between the patient and the outer world.

Sit Mott, an English psychiatrist, is responsible for what is now known as *the law of anticipation* in schizophrenia (1910). "Almost invariably in the case of insane parents and offspring, the offspring is affected earlier than the parents" The law of anticipation states: "Increasingly severe onset at earlier ages within multigenerational affected families" (Gorwood et al, 1996). The severity means *space* as more of the brain regions and mental social functioning is affected, the moment of onset means *time* as insane offspring are debilitated earlier on in life. Now we could consider these ideas as pertaining to the precursors of one of the blackest pages in the history of Western civilization. (Shepherd, 1995) We could say that these approaches are a thing of the past and should not concern us any longer. Unfortunately, we are naive in this optimistic viewpoint.

The Kraepelian idea of dementia praecox survived the Second World War and the Holocaust and is now a dominant mainstream in scientific research. In the guise of the DSM III (1980) constructed by Robert Spitzer the idea of dementia praecox came back with a vengeance. (Havenaar, 2005) Neo Kraepelinism (Klerman, 1978) combined with the underlying ideas of Evidence Based Medicine/Psychiatry (EBM/P) (Sackett et al., 2000) make up the core of the reductionist viewpoint which is militantly in vogue these days. Of the Bleulerian approach only the name schizophrenia remains. (Blom, 2007)

Why is this relevant in the current debate concerning schizophrenia research? Because the construction of the new version of the psychiatric bible, the DSM 5, might include the proposition of a very risky new diagnosis, namely psychosis risk syndrome or attenuated psychosis syndrome.[6] In 2013, we may be able to label certain young individuals as at risk of becoming psychotic. These subjects do not have psychotic symptoms yet, but from our research we think that they should be treated *before* things worsen. Giving patients possible harmful neuroleptic medication or other intrusive therapy as prevention opens up an deontological debate of the utmost importance and urgency.

2.2 Critique

L. S. Penrose delineated a number of potential ascertainment biases that could lead to spurious conclusions of anticipation in affected parent-offspring pairs, the most

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[6] "Nevertheless, we speculate that the genes may all converge functionally upon schizophrenia risk via an influence upon synaptic plasticity and the development and stabilization of cortical microcircuitry. NMDA receptor-mediated glutamate transmission may be especially implicated, though there are also direct and indirect links to dopamine and GABA signalling. Hence, there is a correspondence between the putative roles of the genes at the molecular and synaptic levels and the existing understanding of the disorder at the neural systems level. Characterization of a core molecular pathway and a 'genetic cytoarchitecture' would be a profound advance in understanding schizophrenia, and may have equally significant therapeutic implications." (Harisson et al, 2005)

frequently studied sample type (Penrose, 1948).One bias was the preferential selection of parents with a later AAO[7] of illness, because reduced reproductive fitness in individuals with severe, early- AAO illness led to their exclusion from study. A second bias was the preferential sampling of offspring with earlier AAO and more severe illness, who are more likely to be treated and therefore identified for study than are those with later AAO and/or less severe illness. A third bias related to the recruitment of affected pairs over a limited time frame, favoring the selection of pairs with later-AAO parents and earlier-AAO offspring.

How can we diagnose objectively? Only on the basis of what is already present and obvious. Doing away with this symptomatic assessment is dangerous when applied to this perspective because it opens the door to ludicrous suppositions and harmful therapies.

3 Implicit Suppositions and Explicit Proof: Time Perspective and Subjectivity

3.1 Philosophy

If, how and when are we going to treat what has not yet come to be? In the pitch-black darkness of this question we turn to the Age of Enlightenment for illumination on the idea of anticipation.

Kant: "All knowledge, by means of which I am enabled to know and determine a priori what belongs to empirical knowledge, may be called an anticipation.[...] but as there is in appearances something which is not known a priori, which on this account constitutes the proper difference between pure and empirical knowledge, that is to say , sensation (as the matter of perception) it follows that sensation is just that element in knowledge which cannot be at all anticipated." (Kant, 1781[1998]:159)

It is the level of *sensation* which proves difficult. The difference between pure and empirical knowledge is a subjective level. (De Grave, 2004; 2006) Reductionists of all orientation do away with this problem by stating that well grounded empirical findings equal pure knowledge. If you have a certain genetic make up plus the necessary gene environmental interactions, you *will* become insane. This can be known a priori. The whole of Kant's work makes it clear as day that this stance towards scientific knowledge is dangerously naïve. Doing away with the subjective variance means doing away with the experiential level of relevance, the essence of the question. Thomas Aquinas gave it a religious turn in *De ente et essentia* without coming to a satisfactory conclusion. (1252-1256 [1965])

Following and commenting Kant, Hegel wrote: "But it is just this word that indicates what is posited is not a being [i.e. something that merely is], or essence, or a universal in general, but rather something that is reflected into itself, a subject. But at the same time this is only anticipated. The Subject is assumed as a fixed point to which, as their support, the predicates are affixed by a movement belonging to the knower of this

[7] Age At Onset

Subject, and which is not regarded as belonging to the fixed system itself; yet it is only through this movement that the content could be represented as Subject. The way in which this movement has been brought about is such that it cannot belong to the fixed point; yet, after this point has been presupposed, the nature of the movement cannot really be other than what it is, it can only be external. Hence, the mere anticipation that the absolute is subject is not only *not* the actuality of this notion, but it even makes the actuality impossible; for the anticipation posits the subject as an inert point, whereas the actuality is self-movement." (Hegel, 1807 [1977]: 13) From a dialectical or hyper-dialectical perspective the Truth of any matter of enquiry is not to be found as a solid point of reference, but as a moment in the ongoing process of self discovery and explanation. Time is of the essence is this department because we have to take the decisive moment of coming to a conclusion seriously, because it is an ethical choice that the perceived knowledge obtained so far is both possible and sufficient to support the anticipated conclusion we choose to stand by.

3.2 Psychoanalysis

Now the impression could arise that only the objectivist tradition struggles with these issues of anticipation. Using current psychoanalytical insights in the debate on psychosis, we will demonstrate that they also encounter difficulties in this field. (De Grave, 2013)

Freud did not have that much clinical experience with psychotic subjects. In the process of working out the psychoanalytical theory he did take up the question of psychosis at two important junctures. In his comment on the work of *Daniel Paul Schreber*, he proposed an etiological theory of psychosis. Psychotic patients struggle with their homosexuality and have problems coming to terms with their bisexual orientation. (1911 [2001]: 59-63) In 1911 he considered psychosis to be a sexual problem and for this reason more or less within the confines of his psychosexual theory at that time. Although Freud realized that psychotic disorders did not fit in to his sexual meta theory at that time, in the discussions with Jung, Ferenczi, Bleuler and Kraepelin he held fast to his erroneous ideas.

"Paranoia is precisely a disorder in which a sexual aetiology is by no means obvious; far from this, the strikingly prominent features in the causation of paranoia, especially among males, are social humiliations and slights. [...] So long as the individual is functioning normally and it is consequently impossible to see into the depths of his mental life, we may doubt whether his emotional relations to his neighbours in society have anything to do with sexuality, either actually or in their genesis. But delusions never fail to uncover these relations and to trace back the social feelings to their roots in a directly sensual erotic wish." (Ibid.: 60)

In 1924 he overtly changed his thinking and stated that in pondering over the genesis and prevention of psychosis: "Neurosis is the result of a conflict between the ego and its id, whereas psychosis is the analogous outcome of a similar disturbance in the relations between the ego and the external world. (Freud, 1924 [2001]: 149)

"On the other side, it is equally easy, from the knowledge we have gained so far of the mechanisms of psychoses, to adduce examples which point to a disturbance in the relationship between the ego and the external world. [...] Normally, the external world governs the ego in two ways: firstly, by current, present perceptions which are always renewable, and secondly, by the store of memories to earlier perception which, in the shape of an 'internal world', form a possession of the ego and a constituent part of it. In amentia, not only is the acceptance of new perceptions refused, but the internal world, too, which, as a copy of the external world, has up till now represented it, loses its significance (its cathexis). The ego creates, autocratically, a new external and internal world; and there can be no doubt of two facts –that this new world is constructed in accordance with the id's wishful impulses, and that the motive for this dissociation from the external world is some very serious frustration by reality of a wish –a frustration which seems intolerable. [...] The pathogenic effect depends on whether, in a conflictual tension of this kind, the ego remains true to its dependence on the external world and attempt to silence the id, or whether it lets itself be overcome by the id and thus torn away from reality." (ibid.: 150-151)

After Freud, two threads uncoil in the approach of the psychotic problem: the *Anglo-saxon* tradition, embodied by Melanie Klein and the *Continental* tradition, with Jacques Lacan as its staunchest representatives.

We will not discuss the Anglo Saxon tradition here in detail and content ourselves by stating that their thinking is one originating from a 'primal split' (Grotstein, 1981) followed by a continuous development and oscillation between the psychotic (Sch-P) and neurotic (D) phases in life. (Klein, 1952) A psychotic subject is stuck in a certain phase (paranoid- schizoid) in his mental development or regresses to this phase during a psychotic episode. Lacan on the other hand took up the old tradition of distinguishing between a neurotic, psychotic and psychopathic (perverse) structure of the subject. (Verhaeghe, 2008; De Grave, 2013) There are clear boundaries between these three structures and the distinction is made on the basis of a different bodily position of the subject to the Other. In the oedipal constellation a different existential 'choice' (Neurosenwahl) is made by the subject itself in relation to reality. The neurotic *represses* reality, the pervert *disavows* reality where for the psychotic, reality is *forcluded.*

This point of forclusion was the main diagnostic criterium for making the distinction. (Maleval, 2000) Lacan saw this distinction as a necessary evaluation to come to a possible treatment of the disorder. (Lacan, 1959 [2002]) The motivation was clinical, because in treatment it is of the utmost importance to understand how the subject is more or less in contact with reality and where the specific problems might occur. These problems are noticed during treatment in certain language phenomena[8], peculiar problems in the specular image[9] and in the libidinal energy maintenance[10].

A subject (neurotic, psychotic, perverse) comes into treatment because of a subjective suffering and asks for aid, anticipates it even in the therapeutical relation.

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[8] Relation to the signifier, the Symbolic level

[9] Relation to the body image, the Imaginary level

[10] Relation to the drive, the Real level

Depending on the diagnosis we as therapists provide different curative responses to this request. This is important because certain interventions and interpretations may prove to alleviate the suffering in neurosis where in psychosis the same intervention actually worsens the problem.

In the last part of his teaching Lacan, like Freud, proposed another way of looking at psychosis. In working on the oeuvre of *James Joyce* he came to the idea that neurosis, psychosis and perversion are all dependent on a different way of knotting three existential fields together, the Real, the Imaginary and the Symbolic. (Lacan, 1975-1976 [2005]) His famous Borromean knot was his way of symbolizing this knotting. In psychosis the three existential fields are not tied together as firmly.

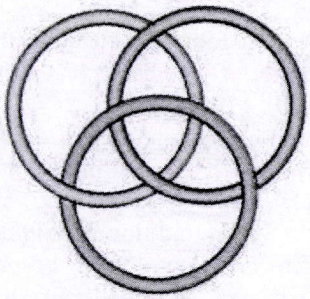

Figure 1: The borremean knot of psychosis

When a certain phenomenon occurs on one level, it is possible that the knot uncoils and this leads to the typical psychotic phenomena (language problems, body problems, delusions, hallucinations). Treatment then means accommodating the psychotic subject to reknot RSI if needed based on his or her own terms, capabilities and life history. We cannot provide an answer, but we can help a patient to find their own individual answers. (De Grave, 2013)

What ties these two approaches together is the idea of triggering off (déclenchement). In the case of a full blown psychosis we can speak of a *before* and *after* the crisis. Was the subject psychotic even before the actual psychotic breakdown? Was he or she pre-psychotic? And if a psychotic episode never occurred, can we then state that the subject does not have a psychotic structure? The psychoanalytical diagnosis is in other words not based anymore on overt psychotic symptoms but on peculiarities, which hint at the possibility of a psychotic structure. After Lacan's death, his son in law and heir Jacques-Alain Miller, took up this point in stressing the idea of the *ordinary psychosis*. (1999; Maleval, 2003) The ordinary psychosis means that we could be confronted with patients without delusions, hallucinations or melancholic symptoms, which are still considered psychotic. (Stevens, 2002)

From this approach onward, diagnosis becomes solely based on the therapeutic contact, without the footholds in the terrain gained thus far. In this, the post Lacanian thinkers fall into the same trap as their Anglo Saxon brethren concerning the diagnosis

of borderline, as being in between neurosis and psychosis.(Stern, 1938; Aronson, 1985) The characteristics of psychosis typical and atypical become so much mashed up that the diagnosis signifies nothing of any sort. All symptoms can hint at the existence of an underlying psychotic structure and there is no way to make any kind of distinction between neurosis, psychosis or perversion. Diagnosis becomes once again a matter in the expert eye of the beholder, not taking the subject seriously.

4 Lichaamskaart: Diagnosis and Therapy

With the technique of *lichaamskaart* we have discovered a new plain of research in mapping out all the problems already stated. (De Grave, Van Den Eede, 2009) *Lichaamskaart* as a therapeutical tool makes room for diagnostic interpretations. It is of the utmost importance that we make clear beforehand that we can never state that a *lichaamskaart* offers *the* diagnostic proof that somebody is psychotic, neurotic or perverse. There is no such thing as the "..." *lichaamskaart* that demonstrates this diagnostic differentiation. They should always be handled with care because of this reason. *Lichaamskaarten* are always constructed in a therapeutic relation and this has to be kept in mind in all interpretations, lest we fall into the objectivistic trap of making a final diagnosis.

Lucia Van Den Eede came up with the idea behind lichaamskaart 18 years ago in the process of making nonverbal therapy more concrete and accessible to psychotic patients. Starting from the drawing of mandalas (Sanskrit for Circle shaped form) in sessions and their possible uses in nonverbal therapy, she found them too abstract and looked for a way to make the idea of drawing form and content of the bodily experience more hands on, closer to the actual shape and size of the body. In this way, *lichaamskaart* came to light.[11] To her amazement, patients seemed to continuously draw the same distinctive patterns in their *lichaamskaart*. Over time, these patterns more or less remained. This may mean that we now might have a possible way of distinguishing grand categories of psychic structure and the ability to further refine them, depending on the shape, content and size of the *lichaamskaart*. Of course, *lichaamskaart* should never be seen as a stand alone technique for making diagnostic differentiation. Especially in the case of suspected psychosis all relevant information should be taken into account. A *lichaamskaart* which hints at psychotic, neurotic of perverse structure is not proof of the underlying psychological make up, only a hypothesis to be placed in the context. In all other cases, lichaamskaart runs the risk as to fall into the same reductionist trap as the *psychosis risk syndrome*.[12]

The set up should be double blind from the onset, the therapist not knowing the diagnosis of the patient and the patient not being told his or her diagnosis beforehand. We are well aware of the fact that the hypotheses we put forward in this heading are speculative and deserve a lot more research. As in all truthful experiments and therapeutic instruments, we put our data forward to achieve some kind of synergy in

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[11] For the technical aspects of lichaamskaart, see De Grave, Van Den Eede, 2009

[12] http://www.nature.com/news/psychosis-risk-syndrome-excluded-from-dsm-5-1.10610

working out the understanding of *lichaamskaart*. We have seen over the years that *lichaamskaart* as a nonverbal therapy is at least clinical effective and could yield diagnostic benefits if handled with care.

4.1 Pankow (The Dasein of the Schizophrenic)

One female analyst was very well aware of the problem of anticipation and body disorders in psychosis : "There are two ways of accessing the understanding of psychosis: the outsider view, that bounders on the nosographic psychiatric classification, and the insider route, or the path traversed *with* the patient, the "descent into hell", that opens the psychotic world in all its plenitude. How to find access to the psychotic experience? [...] Without the knowledge of the structure of the unconscious that Freud developed as an instrument in the treatment of neurosis the analytical conquest of psychosis would have been impossible. Because there is but one unconscious. We better avoid the usage of the theory of neurosis when we want to come to terms with the analytical therapy with psychotics. The phenomenon of psychosis cannot be reduced to concepts like repression and the neurotic defense mechanisms. Twenty years ago I proposed the following formula: *The difference between neurosis and psychosis exists in the fundamental structures of the symbolic order that we find in the heart of language and that contain the primary content of the body. These are destroyed in psychosis, whereas in neurosis they are merely deformed.*" (Pankow, 2006: 13, our translation) To understand the differences in neurosis and psychosis we have to look at the body and linguistic phenomena. But, in neurosis we have a theory to explain what is going on, whereas in psychosis this meta- theory is still lacking. She continues: "It is in this perspective that my work is situated. I do not want to discuss the chances of healing of one psychosis or other through psychoanalysis. Neither is it my intention to work out some kind of genetic theory regarding psychosis. I am now in the internal world of the psychosis and I describe what happens in this threatened inner world. Besides everything, this enables both the patient and the doctor to find an island on sure ground here. This way the universe of the psychotic appears to us as a broken down universe, where every part is at a lesser or greater distance from the next. These distances can differ if some unforeseen gap opens up. Why? I do not know. I just see it happen. We can gain terrain, we can close up these gaps. Maybe the secret of psychotherapy with psychotics lies in this summary: a certain intuition in observation where we take notice of the slightest gap that closes. In most cases we do not know if the terrain gained will hold or if another void will open in the same place. Important in this measure: often we see in this 'terrain of debris' a 'geological layer' that looks like another layer, observed in other fragments. These are what I try to come in contact with, to unify similar fragments on different spaces. I call this process dynamic structuring with the connection of seemingly lost unity between dispersed psychic layers as a goal. It is through this dynamic structuring we gain terrain. The first terrain that needs structuring, even in part, is the unity of layers through which the recognition of a body image becomes possible. Working on this fragile image haunts us through our interventions up to the acceptance of a unisexual body. It is in this respect that we can

introduce the notion of time to continue in a classical analysis." (Ibid.: 14-15, our translation)

4.2 Two Examples: the Limit Function of Psychotic Distress

In *lichaamskaart* we have a diagnostic and therapeutic instrument to work out the ideas set forth by Pankow. We will give two examples from our ongoing research: The first patient was initially diagnosed as borderline (BPD). She had a lot of problems in coming to terms with her feelings of anxiety, professional problems and relation problems. When she came into treatment, she was confronted with rather psychotic symptoms, but because of the grounding diagnosis all these symptoms were seen within the borderline frame work. From the hetero anamnesis we found that she has no family history of psychosis, only problems of anxiety and depression. Her first *lichaamskaart* took witness to a seemingly prepsychotic current. She was on the verge of a new psychotic breakdown. For this reason, we directed treatment to psychosis prevention and a resocialisation as soon as possible. Working on her *lichaamskaart*, she stressed the boundaries of her bodily experience and the exchanges between the inner and outer world. Through drawing and talking about this boundary phenomena she was able to keep the psychotic elements at bay and pick up life outside psychiatry, though with great difficulty. We have no recent *lichaamskaart* for this patient, so we cannot know how it may have changed over time. The second patient was also diagnosed as borderline (BPD) but with a seemingly more overt psychotic strain (possible schizophrenia). She was confronted with clear psychotic symptoms from a psychiatric point of view (voices, visual, tactile and olfactory hallucinations, loss of self, panic attacks) besides Post Traumatic Stress Disorder, attachment disorders, educational disorders and existential problems. From the hetero anamnesis we found a prevalence of more severe psychiatric dysfunctions in the family like alcoholism, psychosis, psychosomatic illnesses, severe depressions and dementia.

In the first *lichaamskaart* we found a more chaotic *lichaamskaart* with traumatic elements. Working on the *lichaamskaart* the experience of trauma came to the fore in the content. Further on in the treatment she made 3 new *lichaamskaarten*. These were better structured. She added the elements she struggled with, dealing with sexual inhibitions, auditory and tactile hallucinations and anxieties. In all sessions the effects of this personal structuring were noticeable. At the closure of her treatment she constructed a final *lichaamskaart*. In this the stability was still present, but the effects of the long enduring residential treatment (5+ years) are present in the shape and content of the *lichaamskaart*, akin to personality disorders.

Considering these examples we find that the psychotic vulnerability might actually be a disposition. In the first example no genetic clues were noted, whilst in the second example a lot of genetic elements hinted at a disposition. In both cases it is important to note that to our experience and the anamneses none of the siblings were overtly psychotic. They were the only 'exceptions' in the 'normal' family life. The psychotic disposition may be inherited and not a matter of choice or mishaps in the walk of life. As all current research agrees upon, psychosis is not strictly a genetic disease, you need

certain triggers (gene environment interactions) that make it run amok. This finding opens up another dimension. If we are able to treat patients at the right time we may be able to help them to organize and structure their psychotic/traumatic experiences so they do not lead to the painful breakdown which we all can recognize as psychotic (perplexity, stupor, catatonia, amentia, melancholia, mania,...). And even if the chaotic breakdown did occur, we are left with ample opportunities to augment the living condition and feeling of wellness through therapeutic support. The decline is not a necessity, even in the case of a substantiated psychosis. Wither dementia praecox! In the first example treatment was oriented to early detection and prevention of a new psychotic breakdown. We anticipated a breakdown and were able to keep these chaotic disturbing elements at bay. This was partially successful and the patient is able to work out her life outside of the Psychiatric Centre. In the second example we tried to reconstruct the body in relation to the image of self and towards the others. She now has the tools and the prowess to work out her personal problems in psychotherapy. In both cases it is important to put the work in the *lichaamskaart* next to the other avenues of care, which enabled both to put the diagnosis of psychosis between brackets.

Both examples show that time is of the essence in diagnosis and treatment. We can change certain aspects of the bodily experience of self, staying true to the suffering of the specific patient. This is a work of many, as each therapist during treatment tries to alleviate the suffering from his or her expertise angle in the therapeutic contact. Good communication around the suffering and the diagnosis is of the utmost importance in communicating with all partners involved (psychotherapy, nonverbal therapy, family therapy, socio-therapy, social work, psychiatry,...) *Lichaamskaart* should never be seen as a diagnostic *or* as a therapeutic instrument. The two are intimately interwoven in the process of mapping the terra incognita of the unconscious. Each of the 400+ number of *lichaamkaarten* drawn up to this day lay evidence to the fact that in neurotic disorders the body image is deformed in some way, where in psychosis it is destroyed up to a certain degree. This does not mean that we now have a new evidence based form of diagnosing or treating psychotic patients if that were to entail that a reductionist view point is the condition sine qua non. In essence, *lichaamskaart* has the capacity to open up a discussion field of diagnosis and therapy if it can remain true to the complex framework that lies in its core. *Lichaamskaart* as a synergic tool can bring us to new insights and ways to work together *with* the patient from our different and limited perspectives as to better help our psychotic patients.

5 Conclusion

Is time of the essence? It boils down to two distinct questions. Concerning anticipation in the patient we have to understand that a subject comes into treatment because of a certain ailment, and is not asking for a diagnosis. He or she hopes that another 'professional' subject will be able to alleviate the level of suffering. They turn to health care because they anticipate that support may be given. Sooner or later, they will come to realise that no therapist or diagnostician is able to solve their problems in their stead. As human beings we are only able to cure ourselves, albeit with the right

kind of guidance and support. The first question is in essence: *can you help me*? Regarding the anticipation in the therapist this question is answered from his or her background of expertise. Understanding the cry for help depends on an interpretation of this utterance. Depending on our diagnostic vantage point we try to understand what it is that ails the patient. Not listening to our patient because we already know what, how and why they are going to say what they will say is reductionism in its ugliest form. The second question should in essence be: *how can I be of help*?

The respectful exchanges in between these two anticipatory tensions are the essence of diagnosis and therapy. Knowing what to treat, when to treat and how to treat come after. How to treat what has not yet come to be is an ethical question and should always and everywhere be patient centered.

References

Aronson, T (1985) Historical perspectives on the borderline concept: A review and critique. Psychiatry: Journal for the Study of Interpersonal Processes. Vol 48(3), pp. 209-222

Aquinas T (1252-1256 [1965]) De Ente et Essentia. http://dhspriory.org/thomas/DeEnte&Essentia.htm

Bentall R (2004) Madness Explained: Psychosis and Human Nature, Penguin Books.

Bleuler E (1908) Die Prognose der Dementia praecox (Schizophreniegruppe). Allgemeine Zeitschrift für Psychiatrie und psychischgerichtliche, Medizin 65 pp. 436–464.

Bleuler E (1911 [1950]) Dementia Praecox or the Group of Schizophrenias. Translated by Zinkin J. New York, International Universities Press.

Bleuler E Jung C (1908) Komplexe und Krankheitsursachen bei Dementia Praecox. Zentrallblatt für Nervenheilkunde und Psychiatrie 31 pp. 220-227.

Blom J (2007) A hundred years of schizophrenia: from Bleuler to DSM-V, Tijdschrift voor Psychiatrie 49(12) pp. 887-95.

De Grave D (2004) Time to Separate the Men from the Beasts: Symbolic Anticipation as the Typically Human Subjective Dimension, CASYS'03 International Conference: COMPUTING ANTICIPATORY SYSTEMS, Daniel M. Dubois (Editor), American Institute of Physics, AIP Conference Proceedings, Volume 718, pp. 435-444.

De Grave D (2006), "The Implosion of Reality: Schizophrenia, the Anterior Cingular Cortex and Anticipation", CASYS'05 International Conference, International Journal Computing Anticipatory Systems, Volume 18, pp. 298-314.

De Grave D and Van Den Eede L (2008), From Insufficiency to Anticipation, an Introduction to 'Lichaamskaart'. CASYS'07 International Conference, International Journal of Computing Anticipatory Systems, Volume 21, pp.145-155.

De Grave D (2012) "The Readiness is all? Closure Remarks on the Psychotic Anticipatory Experience of Time and Space". CASYS'11 International Conference, International Journal of Computing Anticipatory Systems.

Falzeder E (2007). The Story of an Ambivalent Relationship: Sigmund Freud and Eugen Bleuler. Journal of Analytical Psychology 52 pp.343-368.

Freud S (1911 [2001) Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides) In: Complete Psychological Works Of Sigmund Freud, Vol 12 pp.3-84.
Freud S (1924 [2001]) Neurosis and Psychosis In: Complete Psychological Works Of Sigmund Freud Vol 19 pp.149-156.
Green M (2001) Schizophrenia Revealed: From Neurons to Social Interactions, Norton.
Harrison P Weinberger D (2005) Schizophrenia genes, gene expression, and neuropathology: on the matter of their convergence. Molecular Psychiatry. 10(1) pp. 40-68.
Hegel G (1807 [1977]) The Phenomenology of Spirit. Translated by Miller A. Oxford Press.
Grotstein J (1981) Splitting and Projective Identification. New York: Jason Aronson.
Havenaar J (2005) Waarom een diagnose schizofrenie?, Tijdschrift voor Psychiatrie, pp. 149 – 155.
Hoff P (2012) Eugen Bleuler's Concept of Schizophrenia and Its Relevance to Present-Day Psychiatry Neuropsychobiology 66 pp. 6-13.
Gorwood P Leboyer M Falissard B (1996) Anticipation in schizophrenia: new light on a controversial problem. American Journal of Psychiatry 153(9) pp. 1173-1777.
Holmes D Murray S Perron A Rail G (2006) Deconstructing the evidence-based discourse in health sciences: truth, power and fascism International Journal of Evidence Based Healthcare 4 pp. 180–186.
Kant, I (1781 [1998]) Critique of Pure Reason, translated. and edited Guyer P and Wood A, Cambridge: CUP.
Kaplan R (2008) Being Bleuler: the second century of schizophrenia. Australasian Psychiatry. Oct;16(5) pp. 305-11.
Klein M (1952) The mutual influences in the development of ego and id Psychoanalytical Study Child 7 pp.51-53.
Klerman G (1978) The evolution of a scientific nosology. In Schizophrenia: Science and Practice (Ed. J. C. Shershow). Cambridge, Mass: Harvard University Press.
Lacan J (1959 [2002]) On a question prior to any possible treatment of psychosis, In: J. Lacan, Écrits: A Selection (translated by Bruce Fink), pp. 531-214. Norton.
Lacan J (1975-1976 [2005]). Le Séminaire, livre XXIII, Le sinthome (texte établi par J.-A. Miller). Ed. du Seuil.
Mott F (1910) Hereditary aspects of nervous and mental diseases. British Medical Journal 2 pp.1013–1020.
Maletic (2011) http://www.cmellc.com/Home/TreatingtheWholePatient/articleType/ArticleView/articleId/4787/Schizophrenia-and-MDD/
Maleval, J (2000) Forclusion du Nom-du Père. Le concept et sa clinique. Ed. du Seuil.
Maleval JC (2003) "Elements pour une apprehension Clinique de la psychose ordinaire." Séminaire de la Découverte Freudienne 18-19 janvier 2003 Rennes.
Miller JA (ed.) (1999) La Convention d'Antibes, La psychose ordinaire Seuil
Pankow G (2006) L'Etre-là du Schizophrène Contribution à la méthode de structuration dynamique dans les psychoses, Aubier.

Penrose L (1948) The problem of anticipation in schizophrenia genetics. In Howells JG (ed): ''Modern Perspectives in World Psychiatry.'' Edinburgh: Oliver and Boyd, pp 3–19.

Sackett, D Straus, S Richardson, W Rosenberg W Haynes R. (2000). Evidence-based medicine: How to practice and teach EBM. Edinburgh: Churchill Livingstone.

Shorter P (1997) A History of Psychiatry: From the Era of the Asylum to the Age of Prozac, Wiley Press.

Shepherd M (1995) Two faces of Kraepelin, British Journal of Psychiatry 167, pp.174-183.

Spitzer R (ed.) (1980) DSM-III. Diagnostic and Statistical Manual of Mental Disorders (Third Edition). American Psychiatric Association.

Stern, A (1938) Psychoanalytic investigation of and therapy in the borderline group of neuroses Psychoanalytic Quarterly 7 pp.467–489.

Stevens A L (2002) What One Calls «Untriggered» Psychoses, Courtil Papers http://www.ch-freudien-be.org/Papers/Txt/lysy-fc12.pdf

Tsuang M Stone W FaraoneS (2001) Genes, environment and schizophrenia. The British Journal of Psychiatry 178: pp. 18-24

Webster New World Dictionary (2010) Wiley Press

Verhaeghe P (2008) On being normal and other disorders: a manual for clinical psychodiagnostics Karnac Books.