# A Psychoanalytic Reading of the "At Risk Mental States" Paradigm

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**Abstract:** The "At Risk Mental State" or Ultra High Risk (UHR) state is a condition characterized by the presence of psychotic symptoms of short duration and / or low intensity, associated with a marked impairment of social functioning. In this paper, we hypothesize a psychoanalytic reading of this condition, suggesting the hypothesis that it may interpreted according to the Lacanian concept of "ordinary psychosis". This term refers to forms of psychosis "without clear positive symptomatology", such as psychoses without hallucinations and delusions, or psychoses with bodily disorders such as hypochondria. In our opinion, these conditions should be not interpreted as "at risk" states, but already stabilized clinical forms, although different in their symptomatic expressions. Beyond the recognition of attenuated or transient positive symptoms, these clinical forms must be recognized through a different framework, such as the foreclosure mechanism, the absence of "the name of the father" and the consequent alteration of signification.

**Keywords:** At risk mental states, Lacan, Freud, Psychosis, Ultra High Risk.

## INTRODUCTION

The "At Risk Mental State" or Ultra High Risk (UHR) state is a condition characterized by the presence of psychotic symptoms (eg delusions, hallucinations, disorganized behavior) of short duration and / or low intensity, associated with a marked impairment of social functioning (social and school / work withdrawal) [1].

According to the definition of the DSM 5 of Attenuated Psychotic Syndrome (APS), despite the presence of sub-threshold and transitory psychotic symptoms, the contact with reality is still preserved [2].

It is a phenomenon that affects about 3% of the general population [3].

In the earliest stages, the symptoms consist of disturbances of the flow of consciousness; reduced stress tolerance; difficulty in organizing thought; deficit of social interaction, such as social withdrawal and reduction of emotional expressiveness; positive subthreshold psychotic symptoms that include: unusual contents of thought, grandiosity, suspiciousness, perceptive anomalies, marked decline in functionality [4]. Several comorbid conditions are present, in particular depression and anxiety [5].

The "At Risk Mental State" crosses the definition of "limit state". The fundamental starting point of the UHR paradigm is to identify subjects, typically adolescents, who live on the psychopathological "limit condition" beyond which they evolve towards psychosis [6].

Before the development of the UHR paradigm, these patients were diagnosed in a various way: borderline personality disorders, anxious or depressive states, adaptation disorders. Frequent comorbidity with depression or anxiety, on the other hand, represents a further complication for a correct diagnostic classification of these disturbances [7].

In this work, we hypothesize a psychoanalytic reading of the "At Risk Mental States" paradigm and of the Attenuated Psychotic Syndrome (APS). In particular, we suggest the hypothesis that APS is a redefinition in terms of diagnostic statistical criteria of the Lacanian concept of ordinary psychosis.

To demonstrate our hypothesis, we will start from the Freudian-Lacanian dichotomy between neurosis and psychosis and then we will analyze the hypothesis put forward by Jacques Alain Miller on the possibility of psychotic forms without clear clinical signs of delusions or hallucinations. A clinical case will be reported to improve the discussion.

## THE DISTINCTION BETWEEN NEUROSIS AND PSYCHOSIS ACCORDING TO FREUD AND LACAN

### The Freudian Hypothesis

The Freudian analysis of psychotic phenomena, at that time, was innovative, as it provided an orientative treatment for analytic work with psychotic patients, so much so that it remained a central point in Lacan's later theorization of psychosis.

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In one of Freud's main works on psychosis, the dichotomy schizophrenia/paranoia was conceptualized in terms of psychic decompensation and recovery. His engagement with the Schreber case was significant; he asserted that the delusional phenomena had stabilizing effects with respect to the disorganization of classical schizophrenia.

For Freud, the formation of delusion was a recovery attempt related to the subject's attempt to enter into connection with the world: *"The delusion formation, which we take to be a pathological product, is in reality an attempt at recovery, a process of reconstruction"* [8].

In schizophrenia, disorganization is painful and the individual is often unable to establish basic social relationships, as well as in performing daily activities. On the contrary, in paranoia, the formation of a delusion is often linked to mitigating the effects - not only the classic symptoms of schizophrenia disappear, but the formation of delusion correlates with the reintegration of the subject in relationships with others, even in a modified version.

**The Lacanian Hypothesis**

In Lacan's theory, the distinction between neurosis and psychosis remains central and fundamental for the conceptualization of clinical practice.

In the classical Lacanian theory of psychosis, introduced in 1950, both the dichotomy schizophrenia / paranoia and the Freudian thesis are central to the description of the psychotic structure [9].

Following Freud's reasoning, Lacan states that the distinction between schizophrenia and paranoia is essential to his theorizing of psychosis.

Through the introduction of the concept of "delusional metaphor", he transformed the ideas of progressive systematization and restitution.

Lacanian nosology appears strongly linked to modern psychiatry. For Lacan, both neurotics and psychotics are inserted into a subjective relationship vis-à-vis with another and, in particular, to the signifier known as the "Name of the Father".

The "Name of the Father" is associated with a series of functions that link the subject to the Other; these include castration, symbolic identification, desire and naming of one's name [10]. Fundamentally, the "Name-of-the-Father" is a signifier that regulates the unconscious, in part, through the creation of a structural limit (that is, castration) to the capacity of the associated self-enjoyment subject.

Problems with metonymy are underlying many language disorders in psychosis such as the loss of associative links and the breakdown of syntax; in this sense, the one - to - one connection between the signifiers is interrupted.

On the contrary, the absence of the paternal metaphor in psychosis determines in the subject a use of language that differs significantly from that of the neurotic subject [11].

The absence of an anchor to the signifier, the Name-of-the-Father, can produce radical disturbances to subjectivity, such as the linguistic impossibility of representing specific aspects of subjective experience [12].

The metaphorical function serves instead to designate the position of the subject in the signifying chain, and is intimately linked to the question of meaning and identity; in this sense, the absence of the signifier, the Name-of-the-Father, can have significant consequences [13].

This is particularly evident in the subject's relationship with sexuality. The Lacanian theory of psychosis recalls the concept of "unitary psychosis" [10], starting from the supposition that the symbolic foreclosure mechanism is a necessary and sufficient condition for the psychotic structure.

Unitary psychosis is characterized by a single fundamental mechanism underlying all non-organic psychoses, despite significant variations in symptomatology, and recognizing the different subgroups of psychoses - schizophrenia, paranoia and melancholy - which exist.

This is a fundamental aspect to be taken into consideration, because, for Lacan, the emphasis on the concept of unitary psychosis is of considerable importance for the attempt to overcome the "paranoia / schizophrenia" dichotomy of classical psychiatry.

In this area, the distinction between schizophrenia / paranoia emerges from the clinical observations of psychotic symptomatology; on the one hand, this dichotomy brings about a nosological distinction: for example, psychotic phenomena are often complex and variable in schizophrenia.

Systemic delusions, confabulations, hallucinations, social withdrawal and disorganized behaviors such as vegetative states, bodily disturbances and incoherence in cognitive processes can indeed be encountered.

On the other hand, the dichotomy schizophrenia / paranoia supposes that psychotic phenomena have an evolutionary tendency that starting from abstract and disorganized states become systematized forms [7]. In this sense, clinicians who have long observed the progressive and evolutionary tendency of psychosis, evaluate the disorganization inherent in classical schizophrenic symptomatology by linking it to a systematic paranoid delusion.

In these cases, the symptoms and disorganization of schizophrenia will disappear with the emergence of systemized delusional phenomena.

## NON DELUSIONAL PSYCHOSES

However, placing excessive emphasis on the paranoid spectrum of psychosis and on the mechanisms encountered in paranoia has meant that non-delusional forms, particularly in the schizophrenic spectrum, have been poorly understood to date.

A Lacanian psychoanalytic perspective, Paul Verhaeghe's theory of psychosis [14] and Miller's idea of the concept of "ordinary psychosis" have determined the emergence of conceptual approaches diverging from classical expression of psychosis [9].

In Lacanian psychoanalysis, psychosis continues to be an important focal point for theoretical developments concerning clinical experience. However, two new and important developments have emerged in the last decade following the Lacanian approach as well as its theories about psychosis.

Paul Verhaeghe, in the book "On Being Normal to Other Disorders: a manual for clinical psycho-diagnostics" (2004), provided a "fascinating" approach to psychosis, through a synthesis between Lacanian psychoanalysis, the Freudian theory of neurosis and the psychoanalytic theory of attachment [14].

In his theory his proposal is important, that is to say forms of psychosis "without symptomatology", i.e. those forms not considered by contemporary psychiatric nosology, such as psychoses without hallucinations and delusions, or psychoses with bodily disorders such as hypochondria.

He also provided a specific treatment logic for those cases of psychosis that fall roughly in the schizophrenic spectrum.

In contrast to this vision, Jacques-Alain Miller [9] a pupil of Lacan, introduced a theoretical approach to which he refers to the term "ordinary psychosis". This term refers to an epistemic category - the opposite of the nosological category - in which the link between psychic decompensation and stabilization is often encountered in the treatment of psychosis.

Both proposals therefore present themselves as an answer to a new clinical phenomenon, in order to overcome the limits of Freudian and Lacanian theories.

In fact, it is a "clinical anticategory" because its "discrete signs" do not constitute a closed whole, i.e. they do not allow a proper classification. Ordinary psychosis responds, therefore, to a logic, not of class, but rather "arbitrary and conjectural". This means reiterating, now more than ever, that the psychoanalytic clinic is a case-by-case clinic, under transference, which puts into question the very concept of diagnosis, or that procedure that allows one or more phenomena to be traced back to one category, to a closed class of elements.

In a pragmatic way, we can think at ordinary psychosis as a way of recognize psychosis when the signs that attest to it, for one reason or another, are not evident. To identify an ordinary psychosis would then be equivalent to saying that one is faced with one psychosis, even in the absence of manifest symptoms.

The syntagm «ordinary psychosis» has an advantage and an inconvenience. The advantage it consists in promoting the signifiers «psychosis». Because this allows you to break with positions «borderline». And he shows us unequivocally that we can situate psychosis, beyond the evidence of its habitual phenomena. The inconvenience lies however in his time in the act of acquiring the word "psychosis".

## CLINICAL CASE

### L. is 19 Years old

He has been in contact with a psychiatric service for about a year for an anxiety disorder. Because of this symptomatology, he interrupted his studies. There is no family history of any psychiatric disorders.

During the interview L. seems to be in great difficulty, he can't speak fluently, keeps his head down,

does not cross the eyes of the interlocutor. He makes long pauses between one word and another and demands that the mother remains in the room during the consultation. He explains that he feels at a disadvantage in comparison with the others, he can't express a concept for the fear that he can offend the interlocutor. He is also inhibited to tell simply how he feels and he prefers not to speak to avoid offending anyone. Instead he prefers to write short stories connected to one another by the presence of a common phrase. This way of telling reflects the structure of his thought. L. says that he can't stop his thoughts as anything that comes to his mind recalls another thought and so on to infinity.

According to L., everything he thinks may be real. One thing is real if it can be thought. Since thoughts are chained to infinity, things are also chained to infinity. This endless chain of possibilities generates anguish. L. makes an example: "It is possible that there is a glass in the street, it is possible that I have crossed this road, it is possible that I have stepped on the glass, it is possible that I have dragged the glass inside the house, it is possible that the glass is finished on the floor of home, it is possible that I have trampled him barefoot, it is possible that it makes me sick, …".

He often sees glass in the bed but comes to the conclusion that these perceptions are impossible since no injury is caused. The comparison with the psychiatrist helps him to understand that he is the victim of this endless chain of thoughts. He is aware of this mental mechanism. DSM 5 criteria for attenuated psychotic syndrome are satisfied: there are transient delusions (the belief that he had dragged glass into his bed), hallucinations (he sees glass in the bed) but reality test is still preserved (after long trials he is convinced that it is impossible that there is the glass). The structure of the language of L. follows a logical thread), but it hasn't a point of stop. According to lacanian psychoanalysis, we can say that there is not the "point de capiton" (« C'est le point de convergence qui permet de situer rétroactivement et prospectivement tout ce qui se passe dans ce discours », Seminar III). Point de Capiton or "quilting point" "anchoring point" is the interaction of the signifier and the signified which they are knotted together, fixed and stabilized. In the daily symbolic world of discours, the continuous unstable sliding of the signifier is separated from that of the signified. If not with the point de caption, there would not be a fixed position to situate the dissemination of meanings. A certain number of these points "are necessary for a person to be called normal" and "when they are not established or when they give way" the result is psychosis. In the psychotic experience "the signifier and the signified present themselves in a completely divided form."

## CONCLUSION

In this article we hypothesize that many "at risk mental states" are actually to be classified as ordinary psychoses. This psychoanalytic reading modifies the paradigm of at risk mental states. Since ordinary psychoses do not manifest themselves through positive symptoms, it becomes useless to calculate how many at risk mental states can evolve towards frank psychoses. In this sense, the definition itself of "at-risk mental state" should be reformulated in another way. These are not "at risk" states, but already stabilized clinical forms, although different in their symptomatic expressions. Beyond the recognition of attenuated or transient positive symptoms, these clinical forms must be recognized through a different framework. The foreclosure mechanism, the absence of the name of the father and the consequent alteration of signification are the elements that must be found in the patient's speech.

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