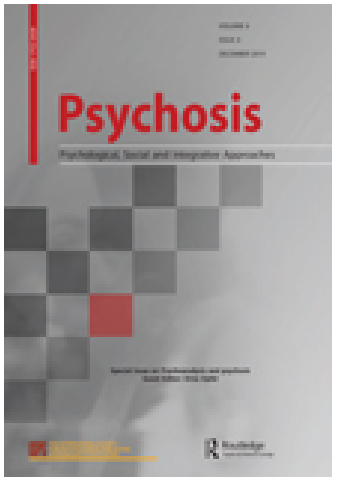

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Engaging with psychosis: A psychodynamic developmental approach to social dysfunction and withdrawal in psychosis

Paula Conway[a] & Andreas Ginkell[b]
[a] Child and Family Department, Tavistock and Portman NHS Foundation Trust, London, UK
[b] Jobs in Mind, London, UK
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Engaging with psychosis: A psychodynamic developmental approach to social dysfunction and withdrawal in psychosis

Paula Conway[a]* and Andreas Ginkell[b]

[a]*Child and Family Department, Tavistock and Portman NHS Foundation Trust, London, UK;* [b]*Jobs in Mind, London, UK*

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Engaging and sustaining constructive relationships with people affected by psychosis is a challenge for clinicians, services and carers. Social dysfunction, withdrawal, negativity and hopelessness are inherent and intractable features of psychosis. We propose that the social difficulties experienced by people affected by psychosis can be addressed through the psychodynamic identification of a psychotic part of mind. In this view, people vulnerable to psychosis are affected by problems that originated during their early psychosocial development. This results in an encapsulation of omnipotent processes, which are a normal and necessary part of infant and child development; however, using these omnipotent processes in adulthood compromises social functioning. Drawing on clinical examples from our work in psychosocial recovery services, we demonstrate how the impact of the psychotic part of mind is expressed in 'negative omnipotence' and 'ethical reversals', and how 'diplomatic interventions' can help sustain engagement and improve psychosocial outcomes for people with psychosis.

Keywords: psychosis; triangulation; psychotic part; negative omnipotence; ethical reversals; diplomatic intervention

Introduction

People affected by psychosis frequently withdraw from social interaction and relationships, which often includes a predictable tendency to disengage from support and clinical services. Social withdrawal and disengagement is usually perceived as a secondary consequence of psychotic disorder due to negative symptoms, described as deficits such as lack of motivation or low mood (Macbeth, Gumley, Schwannauer, & Fisher, 2013). However, there is increasing evidence that social difficulties precede the onset of acute psychotic symptoms and social anxiety is a strong predictor for psychotic disorder (Cornblatt et al., 2011; Michail & Birchwood, 2010).

Rather than seeing social dysfunction and withdrawal as a passive and secondary effect of acute psychotic disorder, we propose that it is a consequence of an active, developmentally established structure of mind. This article aims to outline and explain the psychodynamic conceptualisation of such a structure of mind, based on a differentiation of psychotic and non-psychotic parts of the personality (Bion, 1967; Williams, 2001).

*Corresponding author. Email: paulac@commonwork.org

In this conceptualisation, the psychotic part of the personality interferes with the non-psychotic part (self or *ego*) and its engagement with the demands and opportunities of social life. The psychotic part is developmentally unable to respond to the emotional challenges inherent in adult social life and relationships. The psychotic part ultimately attacks and overwhelms the *non-psychotic part* of the personality to avoid experiencing these emotional challenges.

What appears to be good from a non-psychotic perspective (e.g. being offered help) appears to be bad or a threat from the psychotic perspective (e.g. being humiliated). This leads to dilemmas, erratic behaviour, negativity and withdrawal. The psychodynamic development model of psychosis, as expounded in this article, aims to make this intelligible.

This approach addresses the opposing motivations of the psychotic and non-psychotic parts of mind through diplomatic interventions to sustain therapeutic engagement. This is of benefit to any service or treatment for people affected by psychosis, as without sustained engagement, medical, psychological or social interventions will be compromised.

Early infant development and vulnerability to psychosis

Psychoanalytic theorists mostly focus on difficulties in early psychological development as a significant risk factor for developing psychosis in later life (Britton, 2004; Jackson, 2001). In the early weeks and months of life, psychological development is vitally influenced by the fit between maternal care and the infant's needs. The infant has as yet no capacity to self-regulate its emotional experiences and is entirely dependent on intuitive maternal care to identify and regulate its emotional states (Music, 2011).

The psychoanalyst and paediatrician Donald Winnicott referred to this period (approx. birth to 6 months) as the "mother baby unit". He observed that, while the infant was objectively entirely helpless and dependent on the mother's care, the attuned and devoted maternal preoccupation with their babies' behaviours and emotive expressions gave infants quasi control of their interactions; i.e. baby cries and mother is compelled to respond and remove the (intuited) cause of baby's distress.

He described this early infant–mother interaction as an emotive illusion; i.e. mother makes herself available to be used (and abused) by her infant to a degree which allows the infant to experience mother's attention, holding, feeding, patience and soothing, etc., as being under his/her *omnipotent* control (Winnicott, 1952, 1960, 1963a, 1963b, 1963c). See Figure 1.

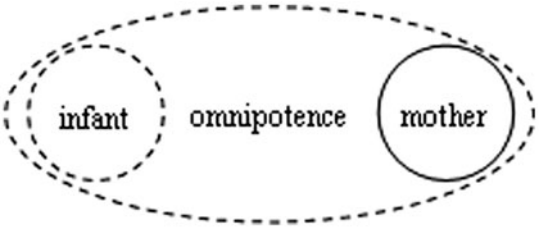

Figure 1. Infantile omnipotent use of the maternal object.

Winnicott reasoned that this early *omnipotent* use of mother enabled the baby to internalise a sense of control over his/her own emotional states and this formed the basis for the baby's development of the *ego* ("I"; self; subject).

He identified the developmental foundations for the strength of a person's *ego*, with a good enough experience of mother's capacity to be used by her baby *omnipotently*. This depends on variables such as the sensitivity and/or health of the baby, the state of mind and health of mother and the environmental context including social/economic factors.

As part of this normal developmental process of omnipotence, the infant uses the mother's mind and body to split off and deposit distress, anxiety, discomfort, rage, etc. The mother may experience this as arousing overwhelming anxiety in herself, but it is required by her baby that she bears and contains these emotions. The psychoanalyst Melanie Klein described these earliest emotional defence processes in her conceptualisation of the *paranoid-schizoid position* (see Klein, 1946).

If an infant experiences this omnipotent use of the maternal object reliably enough, then the child's ego emerges, from the early psycho-somatic unit with mother, as a triangular structure of mind. See Figure 2.

Subjective triangulation

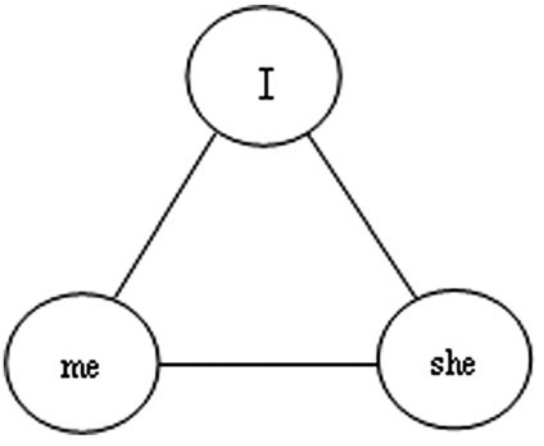

Figure 2. Subjective triangulation.

However, if the infant experiences the return of his projections with unmitigated intensity of anxiety, then the infant cannot internalise (and make his own) mother's capacity to bear and contain distressing states. All the baby has at his disposal is to repeat and continue this process of splitting off and projecting distress into his mother (and later others). If this omnipotent use of the primary maternal object and its function of containing and mitigating distressing experiences continues to fail excessively during its normal early developmental role, then it will continue to be used into adulthood.

For Winnicott, there are two potential trajectories when omnipotent use of maternal care fails; one is his well-known development of the "false self" (a defence against psychosis), the other is the failure of this defence leading to the persistence of omnipotent, psychotic processes in adults (Ellman, 2010).

Clinical vignette: A mother is terrified of changing her baby's nappy. Every time she changes his nappy he screams with rage, she cries, her hands shake and the process becomes increasingly difficult. She says her baby hates her and this undermines her own fragile sense of herself and her maternal ability.

Without an object that can bear his rage, the development of this baby's own capacity to manage his rage is compromised. His interactions with his mother in these repeated experiences amplify anxiety rather than provide relief. Paradoxically (given how frustrating the experience is) his need to omnipotently control his object increases rather than decreases over time, because he is not internalising how to manage his anger by himself.

Oedipal triangulation

The first step in developing the capacity to function in the human social world depends on the establishment of subjective triangulation of the baby's mind – i.e. the emergence of a subject (I) that can experience/think about him/herself (me) and other (she/him/they/it). This capacity is acquired through "good enough" early omnipotent use of mother by her baby and consequently underpins the baby's capacity to conceive him/herself as differentiated from mother.

This provides the basis for perceiving mother as also having a mind/ego, which is also self-reflectively triangulated and thus, is also a subject (I) able to conceive of herself (me) and other (baby/him/her/they/it).

This *triangulation* is a fundamental structure of all human interactions and relationships and introduces the inescapable ambivalence inherent in them. While this triangulation enables us to conceive of what another person may be thinking about, or intending to do, we must concede that their minds and intentions are ultimately beyond our direct control.

The psychoanalytic concept of the *Oedipus complex* addresses the emotional challenge that is associated with this inescapable relational ambivalence. The early infantile emotional defences of splitting and projection rely on omnipotent use of the maternal object in a dyadic unit (*paranoid-schizoid position*). This is followed by the baby's emerging realisation of the "me–not-me" differentiation and the *subjective triangulation* of minds. This presents a developmental challenge – to relinquish the use of omnipotent defences and accept the emotional dependency on, indebtedness to and competitive sharing of the maternal object; and thereafter any desired or loved person or object.

Melanie Klein described this developmental shift in her formulation of the *depressive position* (Klein, 1946). Mental functioning and consequently interpersonal relating in the depressive position is characterised by the capacity to accept and process the depressive anxieties (e.g. envy and guilt) that inevitably accompany oedipal relating; i.e. limitations of control of, dependency on and indebtedness to a loved or needed person. See Figure 3.

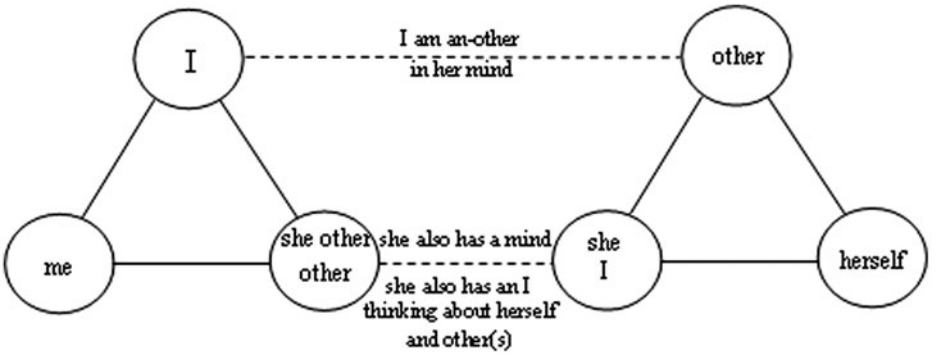

Figure 3. Oedipal triangulation.

The development of oedipal triangulation in the depressive position enables us to know and emotionally process that in every dyadic relationship there is always a third factor, and that crucially this third factor (other, her/him/they/it) cannot be controlled omnipotently. In ordinary development the infantile illusion of omnipotence – I am controlling mother – is gradually relinquished and replaced with ambivalence – mother has a mind of her own which I cannot completely control and this can make me anxious and/or angry. Therefore, the mother I love is also the one I hate. This developmental shift allows us to accept the emotional risks involved in triangulated adult relationships. This *oedipal triangulation* underlies the cognitive concepts of *theory of mind* and *mentalization*. See Figure 4.

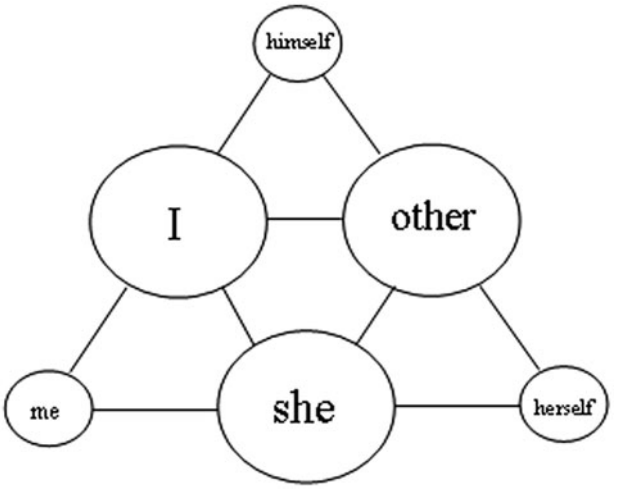

Figure 4. Oedipal triangulation at the core of socialisation.

When this structure is developmentally compromised, attempts at omnipotent control of others will persist as a psychic process beyond its early developmental role, and a person will be vulnerable to regressive use of infantile omnipotence in response to the inescapable emotional challenges of social life. See Figure 5.

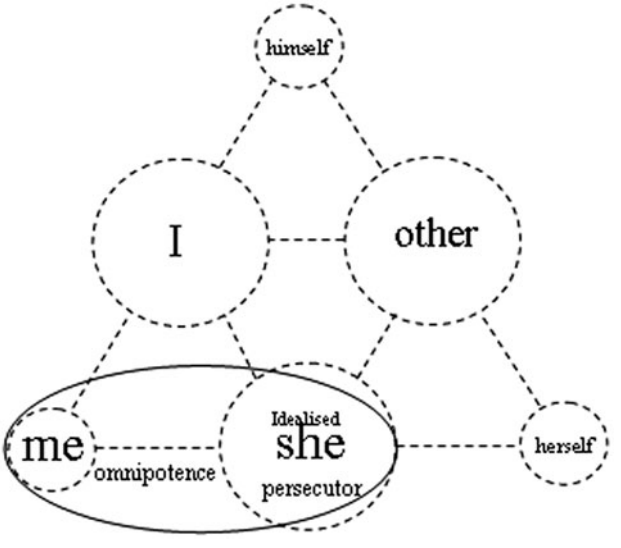

Figure 5. Psychotic regression to infantile omnipotent use of the object and withdrawal from oedipal triangulation.

Such a person, rather than experiencing himself as the subjective owner of his experiences, views others as responsible for receiving and containing all anxieties (as was mother). However, if early developmental experience was one of excessive failure of omnipotent use of the maternal object, this way of relating cannot provide sustained relief from anxiety, but inevitably establishes the other as the source of paranoid anxieties.

Differentiation of the psychotic and non-psychotic parts of mind

Bion (1967) wrote:

> Since [in psychosis] contact with reality is never entirely lost, the phenomena which we are accustomed to associate with neurosis are never absent. [...] On this fact, that the ego retains contact with reality, depends the existence of a non-psychotic personality parallel with but obscured by, the psychotic personality (Differentiation of the psychotic from non-psychotic personalities, In Second Thoughts p. 46).

The non-psychotic part of mind (ego) is developmentally rooted in a good enough experience of omnipotent use of the primary maternal object, resulting in a secure enough sense of self and personal agency. It is characterised by concern with achieving and sustaining engagement in relationships across the range of social life – family, social, sexual, professional. It is able to tolerate and negotiate the emotional challenges and ambivalences accompanying the social nature of our lives, and to

keep engaged with others even when things do not go well. These are the foundations of mental health, which include conceiving of and tolerating the states of mind of others, dependence on others, accepting the limitations of time, change and separations; managing competition, aggression, ambivalence, desire and guilt.

While the non-psychotic part of mind engages in life through relationships, the psychotic part of mind is preoccupied with omnipotent control of social relations, aiming to rid the mind of the emotional anxieties associated with social and intimate relating to minimise the impact of "reality" (Martindale, 2007).

From the perspective of the psychotic part relating is seen to be the source of dangerous, persecutory anxieties, where one will be controlled by the other, or have something unwelcome pushed into or extracted from oneself. To feel gratitude or debt towards a helpful professional may be seen as a plot to be used and exploited; empathy may be experienced as exposing weakness; feelings of desire may be experienced as a dangerous loss of control. See Table 1.

Table 1. Differentiation of psychotic and non-psychotic part.

	Psychotic part/paranoid schizoid position
Accepts	*Rejects and substitutes with*
Responsibility	Sense of entitlement or of being exploited
Limitations	Grandiosity and/or negativity
Change	Sense of unfair treatment or being victimised
Dependence/emotional debt	Feeling of being accused or persecuted
Separations – loss and grieving	Sense of grievance
Ambivalence	Black and white thinking; idealisation and/or denegration
Aggression and competition	Feeling persecuted or being victim
Desire	Sense of emptiness, pointlessness, confusion and/or negativity
Guilt	Feeling persecuted and/or wrongfully accused

Clinical Vignette: Z complains to her support worker how terrible life is at home. Her support worker suggests that she can help Z to move into independent accommodation. Z flares up at her "I don't want your help! If you help me I will owe you and I don't owe anyone anything, that's how I live!"

This blatant rejection of help may be puzzling unless one has a concept of the omnipotent needs and contrary emotional "logic" of the psychotic part. Apart from the obvious rejection of emotional dependency and indebtedness, the psychotic part abhors change (any change, even, or especially change for the better) as it requires the depressing acceptance of loss – i.e. *I don't have and won't ever have the parents I feel I need (needed)*.

Without the emotional ability to accept such loss (*depressive position*) the ordinary ambivalence of social relating will be misinterpreted, avoided, rejected, denied or attacked, only to maintain the omnipotent certainty of grievance, persecution and isolation.

The *psychotic part* is entirely concerned with ridding the mind of depressive, (i.e. reality based) anxieties, which it experiences as unbearable. While this is essentially an infantile and *unconscious* mode of mental activity, the *psychotic part* can

developmentally attain the position of a covert structure of the conscious mind, existing alongside, although unacknowledged and interfering with, the normal functions of the *ego* and *superego*.

The omnipotent demands of the *psychotic part* relate towards the *ego (self)* like or as if it was a *superego* (conscience). The *psychotic part* can therefore obscure the function of the *superego* proper with what appear as superego injunctions. For example, by instructing the *ego* through auditory hallucinations or intrusive/obsessional thoughts with do's and don'ts regarding relationships, social status, hierarchies (Bentall, 2003; Glass, 1985, 1995) However, unlike proper superego injunctions, these internal demands and commands cannot be mitigated by reason and/or experience (*reality testing*). See Figure 6.

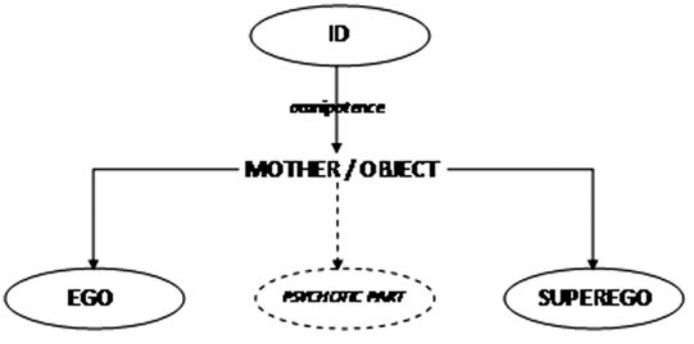

Figure 6. Psychodynamic structure of mind including covert psychotic part.

Clinical vignette: A young man says to his therapist "I can't even buy a pint of milk at the local shop because the voices tell me don't go there the shopkeeper looks at you funny, he thinks you're gay".

Psychosocial impact of the psychotic part of mind

Even though the *psychotic part* is trying to protect and maintain its omnipotent status, nonetheless this requires an *object*, essentially a maternal object (as in infancy), to receive and contain the split off and projected distressing emotions. However, ordinary adult relationships are fundamentally not maternal in nature, but *oedipal* (triangular).

Even in a dyadic clinical or care relationship there is always a third or other implicit, e.g. through the professional boundaries of the relationship and its availability to other clients. The client cannot avoid experiencing a lack of omnipotent control in the relationship. Taking this dynamic into consideration is crucial to understanding the frequent disengagement of people affected by psychosis from treatment and recovery opportunities.

Withdrawal from relationships is an inherent feature of psychosis. Yet avoidance and retreat leaves a person deprived of access to other minds, which are nonetheless desperately needed for the emotional regulation of his/her own states of mind. The psychotic part's "solution" to this dilemma is to resort to the omnipotent generation of delusional objects/relationships.

However, because in infancy attempts at omnipotent use of mother failed to contain the infant's extreme anxieties and emotions (remember the baby rage during the nappy change), the delusional objects created in adulthood inevitably recreate the persecutory anxieties of this early experience. Thus, psychosis makes a person jump out of the frying pan of *oedipal* relationships into the fire of paranoid delusions (symptoms).

Clinical vignette: A young man diagnosed with psychosis was removed from his birth mother at 9 months because of neglect. He was brought up in multiple foster homes. He has engaged in therapy and his social functioning improved, but after two years the therapy has to end. He cannot discuss the ending, but instead describes the emergence of a terrifying delusional belief. There is a new and secret world order which is building huge concentration camps to get rid of anyone who does not comply. He is convinced he will be the first to go because he is of no value. He claims there is no point continuing the therapy as he will be dead within two years anyway.

A conception of psychosis as a specific, developmentally established structure of mind (rather than just a collection of symptoms) and how this structure affects psychosocial functioning can provide an explanation for how psychosocially stressful situations or periods (e.g. change/loss, adolescence) can trigger breakdown, relapse and emergence of symptoms (*regression; stress–vulnerability model*).

This is illustrated in the above vignette, where the emotional challenge of the impending end of the therapy and separation from the therapist triggered the emergence of the delusional symptom, which is expressing the patient's desperate need to matter enough for someone to "take care of him"; albeit expressed entirely through omnipotent grandiosity and negativity, i.e. the "secret world order" seeks to incarcerate and kill him. This is from the psychotic perspective preferable to being left alone to live (rot) in a depressingly indifferent and uncaring world, as evident in the abandonment by his therapist (and originally his mother).

Negative omnipotence

The psychotic part may attempt to avoid the depressive anxieties of oedipal reality through grandiose denials of limitations and/or assertions of power. For example, believing in supernatural powers or a special life path that is always about to unfold. However, this *manic* expression of omnipotence is ultimately unsustainable. Although compelling, these delusions will inevitably encounter the limits imposed by the conditionality and competitiveness of adult life.

The psychotic part can, however, always succeed through the negative expression of omnipotence; i.e. if I can't omnipotently ensure that things turn out well, I can always omnipotently ensure that they turn out badly. While success is never certain, failure is always an achievable option. This can find expression, for example, in a young man stating to his therapist: *"Everything I touch turns to shit."* Or, clients often say that, while they may feel understood: *"It won't change anything."*

*Clinical vignette: A young woman shows how negative omnipotence is the delusional fall back option from the unsustainability of manic idealisation. When at one time in her treatment she thought that she was pregnant, she said to her therapist: "*When my baby is born, there will only be love*." However, her ambivalent feelings about the demands and needs of a baby and her lingering sense that she wasn't entirely sure there would only be love (given her own painful experiences as a baby)*

emerged when she proceeded to say that she thought something was wrong with her cat. Although she couldn't say what, she was nonetheless sure that it would have to be put down.

Characteristically, this young woman also frequently threatened suicide – the ultimate conclusion of negative omnipotence.

Ethical reversal

Given the threat to the omnipotent needs of the psychotic part entailed in ordinary social interactions and relationships, it's assessment of what is "good" or "bad" in these interactions is diametrically opposed to the non-psychotic part/ego. This leads a person vulnerable to psychosis to be plagued by self-defeating doubts and dilemmas.

Clinical vignette: A tells his key worker a convoluted story about his childhood. It is hard to understand, but a theme seems to be emerging. She responds that he seems to be telling her he feels he was betrayed and lied to throughout his childhood. He looks with a bright face and says "that's right, that's really good" then immediately says "We'll have no more of that thank you".

One can hear in A's response the non-psychotic part of him wanting to be understood and the psychotic part which says being understood is dangerous so "we'll have no more of that thank you!"

Clinical vignette: Following years of withdrawal X has started college. His support worker praises him for attending two weeks in a row and doing well. X does not attend college the next week and states that it was "not for him". The support worker is perplexed – he believes that praise and encouragement should result in greater engagement and participation, but the opposite has happened.

As a result of the praise, X's psychotic part believes he is now obliged to attend, or that his support worker is gratified by his attendance, or that he is indebted to his support worker for his praise and encouragement. None of these relational processes that X attributes to his support worker are under X's omnipotent control and the anxiety this provokes can activate psychotic processes and subsequent undoing of progress.

The only absolute control X can have over his future at college is a negative one – he knows if he doesn't attend he will fail. He may tell himself he doesn't need praise (needing anything is a threat to his omnipotence); he knows it all anyway (omniscience); they hate him (paranoia), or he is entitled to the certificate without having to attend (grandiosity), etc.

In this view, his support worker is not perceived as a source of support but as a persecutor intent on pushing anxiety into him albeit in the form of praise. Understanding these dynamics may result in a different approach by the support worker where praise is used very cautiously. For example, the support worker may have said "I think you feel you have made a good start but a part of you may feel that it is not good, or not worth it", as a way of acknowledging and anticipating both ordinary, non-psychotic progress and an omnipotent psychotic perspective on it.

We have found it helpful in our work to identify the presence of the *psychotic part* of mind through the expression of these characteristic and predictable *ethical reversals*: good = bad; love = hate; responsibility = exploitation; gratitude = accusation; concern = exposure; help = humiliation; etc.

As we saw with X who stops going to college after being praised, Z who cannot bear to accept help and A whose psychotic part turns being understood into a dangerous experience, these are the reverse of what is ordinarily expected, and indeed the reverse of what is true for the non-psychotic part of the patient.

Engaging and supporting people vulnerable to psychosis – diplomatic interventions

Health, social care and therapeutic work with people vulnerable to psychosis, is based, either explicitly or implicitly, on a relationship with the client which aims for "progress" or "change", including: better adherence to treatment, increased insight and better psychosocial functioning. Often, service users will not only agree to these aims, but may actively request support to achieve them. Yet from the perspective of the psychotic part, the desire for change is not experienced as benign or neutral. On the contrary, the service user may secretly feel "you want me to get better so you can get rid of me" (annihilation anxiety) or "if I agree that something needs to change, I stand humiliated as I have been exposed as wrong, weak or needing help" (persecutory anxiety).

How to speak to patients/service users about the aims of ordinary life without provoking the *psychotic part* is the difficult task of every practitioner working with people who are vulnerable to psychosis.

This involves the recognition and "diplomatic" consideration of the presence of the psychotic part interfering in ordinary tasks of living and relating. Without this, interventions unwittingly risk provoking the sensitivities of the *psychotic part*, with consequent increased withdrawal and/or psychotic disturbance (*negative therapeutic reaction*: Freud, 1923, 1937, 1940; Horney, 1936; Riviere, 1936).

In our experience, the professional/therapeutic relationship needs to be attuned to and accommodate the omnipotent agenda of the *psychotic part*, while maintaining a firm reality focus. Often clients will keep their psychotic part covert. They will be positive at initial meetings, claim they want help, want to work, study, etc. Rather than go along with this, we have found it helpful to bring the agenda of the psychotic part into the open from the beginning using some basic principles:

Acknowledge:

"You said that you want to do this, but I think a part of you is concerned and does not want to do it."

Accept:

"I think we need to accept that a part of you does not want to do this; yet another part does, and it is important that we keep both views in mind."

Address:

"I don't think that this can be done in an either-or, all-or-nothing way. Whether you do or don't do this – there will be consequences, either way – it is difficult."

Clinical vignette: At an assessment meeting a young man says emphatically that all he needs is a fresh start, and he wants to attend the project three days per week,

starting immediately. The assessor says that a part of him believes he just needs a fresh start and is keen to get started, but perhaps another part knows he has had many "fresh starts" which don't last very long, and perhaps he has more mixed feelings about starting the project and should begin slowly, one day per week.

Understanding that a person vulnerable to psychosis is affected by the covert operation of a *psychotic part* opposing the relational needs of the *non-psychotic part* enables practitioners to directly address and validate the diverging motivational agendas of both parts. To refer to a person affected by psychosis exclusively as a unitary "you" risks entrenching confusion and frustration both for the patient/client and therapist/professional. Attitudes expressed verbally or implicitly that only address the positive, non-psychotic part, e.g. *You have done well, keep at it!*, risk a negative reaction as discussed above, e.g. dropping whatever is going well; and attitudes which express frustration with the psychotic process like: *"You said you want to do that, why did you change your mind?"* or *"You are very anxious today"* are likely to result in denial "*I never wanted to do it"* or *"I'm not anxious"*. This is because speaking only to either the psychotic or non-psychotic agenda risks repeating the unsatisfactory early developmental experience of the totality of the infants experience being misunderstood, ignored or rebuffed.

A *therapeutic stance* entails accepting and containing the *omnipotence* and corresponding *annihilation/persecutory anxieties* of the *psychotic part* while also communicating (over and over again) about the dilemmas of ordinary social participation – *"there are consequences either way – it is difficult"*.

The use of omnipotence is especially evident when questions of control are at stake, for example, before reviews where decisions will be made about a client's continuing involvement in a service. These decisions are not under the client's omnipotent control and he has to bear that the clinician has a mind of her own over which he has only limited influence. We have found it helpful to address these dilemmas, not through reassurance, rather through addressing the agenda of the *psychotic part*.

Clinical vignette: K is due a multi-agency review tomorrow. Today his behaviour is obstructive and aggressive. He refuses to work and throws equipment around. The project manager says to K that he is being disruptive which needs to stop, but she thinks he is behaving this way because he is worried about the review tomorrow. A part of him is trying to influence what she is going to say by making sure she says what a nightmare he is to have on the project and perhaps even pushing her to say he has to leave. She says that this way he feels in control of what is going to happen even if it is the last thing he really wants and certainly not what she wants for him. K turns red in the face and silent. His behaviour settles down and he manages well for the rest of the day.

This is a delicate and emotionally demanding task that requires identifying and addressing infantile *omnipotence* and its defiance of ordinary relational reality (*oedipal triangulation*). The level of challenge to omnipotence acceptable to the *psychotic part* of a particular person is variable and may be very low to begin with, exposing practitioners to rejection – as exemplified in the earlier example of A saying *"We'll have no more of that, thank you"*. Alternatively, to only address and validate the *non-psychotic part* of mind with praise, enthusiasm and encouragement will miss the more complex communication that needs to be understood for engagement to be maintained.

Summary

A psychodynamic developmental model of psychosis proposes that *psychosocial dysfunction* and disengagement from services in psychosis is to a large extent due to the active impact of a *psychotic part* of mind, rather than lack of capacity or motivation. The *psychotic part* of mind is derived from developmental processes during infancy and childhood which lead to the encapsulation and persistence of *infantile omnipotence* beyond its early developmental function into adulthood.

This persistence of *omnipotence* is constituted in a covert structure of the adult mind, the *psychotic part*, which impacts on a person's *ego functions* to the extent of disabling its connection with "ordinary reality" and substituting it with *delusions*. The objective of delusions is to maintain a sense of omnipotent control. In adulthood this is ultimately only sustainable through negativity/paranoia.

The persistence of *omnipotence* particularly interferes with a person's ability to negotiate the emotional challenges entailed in triangulated adult oedipal relating, which requires the capacity to process desire, guilt, competition, separation, limits and loss. This interference causes ongoing motivational conflict between the opposing "ethics" of the *non-psychotic* and *psychotic part* of mind, with resultant ethical reversals.

Engagement with a person affected by psychosis requires taking the agenda of the psychotic part into consideration, and *diplomatically* negotiating the *omnipotent* demands and defensive rejections of *oedipal relations*. Engagement, support, clinical and therapeutic work with people vulnerable to psychosis is akin to being a *peace negotiator*, mediating between the conflicting motivations of the *non-psychotic* and *psychotic parts* of mind.

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