

REVIEW ARTICLE

Links between trauma and psychotic symptoms: Integrating cognitive behavioural and neuropsychanalytic models of psychosis

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Email: mgarrett50@aol.com**Abstract**

Purpose: Cognitive-behavioural therapy for psychosis (CBTp) achieves small to modest effect sizes, which invites the question, ‘What clinical modifications might improve outcomes?’ This paper proposes an integration of CBTp with a neuropsychanalytic approach that in clinical practice might extend the gains achieved by CBTp alone.

Methods: The author conducted a focused review of CBTp research bearing on trauma as well as a review of neuropsychanalytic conceptions of psychological symptoms (‘neuropsychanalytic’ meaning principally psychoanalytic ideas about how the brain maintains affective homeostasis) to identify similarities and differences in these approaches relevant to clinical practice.

Results: CBTp-oriented research shows that not only is childhood trauma associated with psychosis, but psychotic symptoms often contain de-contextualized memories of trauma and embody narrative themes that echo the person's trauma history, findings that mark psychosis as a trauma-related disorder in which psychotic symptoms constitute disguised representations of a person's trauma history. This paper expands the definition of trauma to include the symbolic meaning of events and relates psychosis to a neuropsychanalytic model of the mind in which affect plays a central role, a conceptual lens through which delusions can be seen as meaningful adaptive attempts to maintain affective homeostasis in the aftermath of traumatic experiences. The paper offers an explanation of the developmental origins of the cast of characters and plot lines often encountered in delusional narratives.

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Conclusions: There is considerable potential conceptual overlap between CBTp and neuropsychanalytic approaches to psychosis, which if integrated might lead to better clinical outcomes, in particular in a collaborative development of *schema therapy* for psychosis.

KEYWORDS

delusions, hallucinations, neuropsychanalytic, psychosis, psychotherapy, trauma

INTRODUCTION

Meta-analyses of the effectiveness of cognitive-behavioural therapy for psychosis (CBTp) find small to modest effect sizes (Fusar-Poli et al., 2019; Solmi et al., 2023) with some protocols more promising (Freeman et al., 2021). More recent approaches focusing on intrusive PTSD-like symptoms in psychosis appear to have comparable efficacy (Brand et al., 2018; Hardy et al., 2024). Given its modest outcomes and the high variability in patient response, Newman-Taylor and Bentall (2024) ask whether CBTp has reached the end of its line. They conclude that it has not and advocate a renewed emphasis on the therapist's interpersonal effectiveness, using individualized participant data meta-analyses to guide treatment, while spotlighting key mechanisms in the genesis of psychosis such as trauma, which is the central focus of this paper.

In their perspective piece on the history of cognitive-behavioural therapy for psychosis, Hayes and Hofmann (2017) suggest that advances in theory and technique have created 'a field so broad that it stretches the very term CBTp to a breaking point' (p. 245). In their account, CBTp initially concentrated on cognition (Chadwick et al., 1996; Kingdon & Turkington, 2005) while later expanding in a 'third wave' of treatments focused on the patient's meta-cognitive relationship to their thoughts and feelings, including acceptance and commitment therapy (ACT), compassion-focused therapy (CFT) and mindfulness practice, to mention a few. Recent advances such as digital AVATAR therapy for voices (Leff et al., 2014; Longden, Corstens, Morrison, et al., 2021) and chair, imagery and schema work with psychotic patients (Rhodes & Vorontsova, 2025) may provide additional gains for some patients. For lack of a better descriptor, the broad tent of theory and technique outlined above might be called cognitive-behaviourally grounded treatments (CBTp-G). This paper considers the potential value of including a neuropsychanalytic perspective in the CBTp-G grouping noted above.

Issues to be addressed

This paper stands on psychodynamic ground while reaching towards Hardy's CBTp-G model of trauma-related symptoms in psychosis (Hardy, 2017). This paper conceptualizes psychosis as a *trauma-related disorder*, expands the definition of trauma, and reviews trauma-specific brain changes that attenuate the conscious experience of painful trauma-related affects. It discusses a neuropsychanalytic model of the mind as a self-organizing system that evolved to maintain affective homeostasis in the face of traumatic experiences. It offers a psychodynamically oriented developmental account of the specific content of delusional narratives, including delusional constructions that might at first appear unrelated to trauma. And finally, it argues that CBTp-G theories of psychosis provide a persuasive account of trauma-related intrusions (Hardy, 2017) and rightly emphasize the cognitive processing of anomalous perceptions (Garety et al., 2001) while a neuropsychanalytic model offers a rich account of the specific content of delusional narratives and suggests a psychodynamic answer to the question, 'Why do delusional narratives persist in obvious contradiction to

consensual reality?’ This paper opposes a conception of schizophrenia as essentially a biologically based brain disease while strengthening a psychological model of psychosis that emphasizes the importance of trauma and trauma-informed psychotherapy.

Neuropsychanalysis is a field of theory and practice based chiefly on the work of Panksepp (Panksepp & Biven, 2012), Friston (Friston, 2010) and Solms (Solms, 2021) that integrates neuroscience, psychoanalysis and psychodynamic psychotherapy, elaborated in the journal *Neuropsychanalysis* (founded in 1999). Here, I apply this perspective to an understanding of delusional thinking. Although cognitive biases and maladaptive appraisals are apparent in individuals with psychosis, delusions can be alternatively understood as psychodynamically motivated structures that express a figurative truth about a person's life in narrative form. I suggest that homeostatic regulation of trauma-related affects drives the composition of many (if not most) delusional narratives and that the persistence of delusions that defy common sense cannot be accounted for solely by a cognitive deficit in belief re-evaluation, as posited in the two-factor cognitive model of delusion formation (Coltheart et al., 2011). Rather, delusions may persist because they serve a vital psychological purpose. I describe three clinical cases illustrating this function: an adolescent who became psychotic after her journal was stolen, a woman who claimed psychic awareness of the presence of paedophiles, and a woman who reported travelling to another planet to ‘switch out’ her body. This way of understanding psychotic narratives has significant implications for trauma-informed treatment and research.

PSYCHOSIS AS A TRAUMA-RELATED PHENOTYPE

Research in the last three decades has demonstrated an association between childhood trauma and psychosis (Alvarez et al., 2011; Bonoldi et al., 2013; Cutajar et al., 2010; Larsson et al., 2013; Longden & Read, 2016; Matheson et al., 2013; Muenzenmaier et al., 1993; Scott et al., 2007; Varese et al., 2012). Struck and colleagues found that while 15% of adult subjects with no history of psychiatric illness reported childhood maltreatment, 56.1% of those diagnosed with schizophrenia or schizoaffective disorder reported histories of abuse (Struck et al., 2020). Kraan and associates report an even higher number: 86.6% (Kraan et al., 2015). Sexual abuse involving non-consensual penetration increases psychosis risk ten-fold (Bebbington, 2018). Although correlation does not prove causality, reports of a dose-dependent relationship between the severity of trauma and psychosis suggest a causal connection (Scott et al., 2007; Trauelsen et al., 2015). Not only is trauma associated with psychosis, but psychotic symptoms often contain direct, albeit fragmented, representations of traumatic events or echo themes of a person's trauma history that signal their traumatic origin (Ayalde et al., 2022; Beck & van der Kolk, 1987; Bortolon et al., 2023; Campodonico et al., 2022; Corstens & Longden, 2013; Ellenson, 1985, 1986; Ensink, 1992; Hardy et al., 2005; Longden, Corstens, Morrison, et al., 2021; Longden, Corstens, Pyle, et al., 2021; Maisey et al., 2022; Peach et al., 2021; Piesse et al., 2023; Read & Argyle, 1999; Reiff et al., 2012; Romme et al., 2009; van den Berg et al., 2023).

The above findings linking trauma to psychosis, along with a slowing pace of innovation in biological psychiatry (Stephan et al., 2016) have sparked a renewed interest in trauma-informed psychological treatments for psychotic disorders (Lonergan, 2017). Biological psychiatry that views schizophrenia as a genetically determined brain disease best treated with medication has dominated therapeutics since the advent of the neuroleptic chlorpromazine in the 1950s, marginalizing the role of psychotherapy. In their review of 60 years of placebo-controlled antipsychotic drug trials, Leucht et al. (2017) found that across trials 49% of patients failed to show even a minimal response to medication versus 30% in the placebo group while only 23% of patients showed a ‘good’ response. Only one in seven patients diagnosed with schizophrenia achieves a functional recovery (Silva & Restrepo, 2019), and those functioning best at 20-year follow-up are people who have discontinued taking medication (Harrow et al., 2017). Whatever differences there may be between CBTp-G and a neuropsychanalytic approach, their similarities substantially outweigh their contrasts in the face of the dominance of a reductive biological psychiatry that downplays the importance of psychotherapy for psychotic disorders.

In CBTp-G models of psychosis, hallucinations associated with sexual abuse have been viewed as intrusive de-contextualized trauma memories. To my knowledge, Freud was the first person to describe hallucinations as de-contextualized trauma memories, but unlike CBTp-G researchers who have focused on treatment in community clinics, the psychoanalytic community failed to translate this insight into the care of traumatized patients in public sector psychiatry. In 1896, Freud published the case of Frau K, who as a child was seduced by her brother. She experienced fragmented hallucinatory trauma-related images of the lower part of a woman's abdomen and male genitalia along with ideas of reference and paranoid delusions (Freud, 1896). In *Studies in Hysteria* (Breuer & Freud, 1895) Breuer and Freud observed that patients cordon off trauma memories in hypnoid states that resist voluntary recall, but when brought to consciousness using the technique of free association, symptoms sometimes abate. Current exposure-based CBTp-G therapies for intrusive psychotic symptoms adopt a similar approach that aims at therapeutic abreaction of trauma memories (Peters et al., 2022).

I mention these psychoanalytic antecedents not to simply claim that psychoanalysts planted the de-contextualized flag first, but rather to encourage CBTp-G clinicians to believe that psychoanalysis, considered as a body of ideas rather than a treatment technique, may have something of value to offer in the treatment of psychosis. Despite the psychoanalytic community's having intuited aspects of the conceptual infrastructure of CBTp-G and *schema therapy* (to be discussed at the end of this paper), psychoanalysts (at least in the United States) have largely abandoned the care of psychotic patients, with some exceptions (Arieti, 1974; Garrett, 2019; Karon & Vandenbos, 1981; Lotterman, 2015; Rosenbaum et al., 2012). Instead of translating clinical intuition into modifications of technique, psychoanalysts sequestered themselves in relative isolation from academic psychiatry and psychology, shunning research and care in public psychiatry. To their great credit, CBTp-G clinicians have focused on developing practical tools aimed at improving treatment in public hospitals and clinics. That said, much value can be salvaged from a psychoanalytic understanding of the mind that can be put to use by psychotherapists of various persuasions treating psychotic patients.

DEFINING TRAUMA

A century ago, clinicians defined trauma in terms of a person's reaction to an event (Moskowitz et al., 2019). This changed with DSM-5 criteria for post-traumatic stress disorder (American Psychiatric Association, 2022), which identified disturbing events per se (actual or threatened death, serious injury, sexual violence) apart from their meaning to the individual as criteria for diagnosing PTSD. Although many people would experience any event in the DSM-5 list as traumatic, it is nevertheless *the meaning of an event, not the event* per se, that makes it traumatic. Kilpatrick and colleagues (Kilpatrick et al., 1989) underscore the centrality of meaning in their report of a woman who did not experience post-traumatic symptoms after she was raped. She developed them only later, after learning that her assailant had been apprehended and charged with the murder of another woman. Her realization that she too might have been murdered changed the meaning of the rape and precipitated PTSD.

A psychological trauma might be defined as a reaction to a life event or a series of events where *the meaning and affects associated with an event exceed an individual's psychological coping capacity, thus preventing the memory of the event from being worked through, assimilated, and integrated into the person's prior sense of self and previous mental representation of the world* (Krystal, 1978). Trauma may be physical and obvious to others (as in child abuse) or may arise from a series of events that create developmental conditions that constitute physical or emotional neglect (Alkema et al., 2024) or may arise from the idiosyncratic symbolic meaning of an event that is not apparent to others. Sometimes a psychosis follows a succession of incremental developmental failures, no single one of which is separately traumatic, yet which, taken together, burden the psyche to a breaking point. This path to illness has been called 'strain trauma' (Kris, 1956) or 'cumulative trauma' (Khan, 1963). An example would be the insidious developmental consequences of the actions of loving parents who fail to allow a child's authentic identity to emerge because they insist on their child being someone their child is not (Karon & Vandenbos, 1981; Winnicott, 1960).

Traumatic experiences are commonly linked in extended associative networks to other events, thoughts, feelings, fantasies and perceptions, in which case the trauma trace extends far beyond the episodic memory to which a person might be exposed if able to recall it. Rather, the trauma infiltrates the sufferer's mind, embedding itself in a far-flung matrix of facilitated synaptic connections that fire whenever the person encounters a stimulus (trigger) that is directly or symbolically reminiscent of the trauma. The extent to which adversity resides in a network not contained by an episodic memory may contribute to limited outcomes and heterogeneity of response to psychotherapy. A traumatic memory may be best viewed not as the demarcated mnemonic record held by a person who can reflect on it, but as having become an integral part of the person's psyche.

Clinical case 1

Consider an event that would not register on the Childhood Trauma Questionnaire (CTQ) (Rubin & Feeling, 2013) whose traumatic symbolic meaning precipitated a psychosis. I once consulted in the treatment of a shy 16-year-old (Sally) who suffered a psychotic break the week after classmates stole her private journal from her backpack. Bullied by peers, she had for years struggled to make friends but had failed to find a 'besty'. Her journal contained lyrics for rap music she had composed that she imagined one day would grant her social status. The theft of the journal meant to her that she had lost all possibility of acceptance by her schoolmates. She was devastated by the loss of this developmental road to her future and lapsed into a psychosis in which she claimed that the rapper Jay-Z had arranged a music contract for her. The psychological aim of her delusion was clear. It created an illusory future that quelled her despair. In her delusion, she attains the popularity she hoped her rap lyrics would have afforded in reality. If we were to add symbolic, strain and cumulative trauma to the CTQ, the 56%–86% of psychotic patients now identified as having experienced trauma would certainly rise, further supporting a conception of psychosis as a trauma-related disorder, prompting clinicians to look for associative meanings.

TRAUMA-INDUCED CHANGES IN THE BRAIN AND PSYCHOLOGICAL DEFENCES

Trauma induces changes in the brain that biologically committed stakeholders mistakenly interpret as evidence of an organic brain disease (Read et al., 2014), which underscores the centrality of trauma in the aetiology of psychosis. In a review of changes in brain structure, function and connectivity in people with histories of childhood maltreatment, Teicher and colleagues (Teicher et al., 2016) suggest that trauma-induced brain changes are potentially adaptive efforts to mitigate the disturbing impact of trauma. They report that abused individuals show brain changes in areas specific to the sensory modality in which they were abused. Verbal abuse preferentially damages the auditory cortex and arcuate fasciculus language pathways; witnessing domestic violence reduces the volume and thickness of the visual cortex; sexual abuse results in pronounced cortical thinning in the genital representation field of the primary somatosensory cortex. They conclude that trauma-induced brain changes constitute 'specific modifications to sensory systems and pathways that convey the aversive experience to consciousness [my emphasis], as a means of attenuating effects of repeated exposures and thus reducing stress' (pp. 654–655). Much as a home electrical system closes circuits when current exceeds capacity, the brain has evolved neural circuit-breakers that limit the conscious experience of trauma. Sensory-specific ablations of cortex that attenuate affectively charged traumatic memories serve the same purpose as the psychological defenses depicted in neuropsychanalytic models of psychosis; i.e., they shield people from the painful too-muchness of the conscious experience of trauma memories. These defenses are a primary focus in psychotherapy.

At variance with a belief that consciousness is a product of neo-cortical cognition, Damasio contends (Damasio, 2000; Damasio & Damasio, 2024) as have others (Solms, 2021) that consciousness first arose

in brainstem and subcortical nuclei prior to the development of the neocortex, which came later in evolution, and that this primal consciousness is *affective* rather than cognitive. According to Damasio, affect allows an “I” at the centre of experience to claim sensory impressions as ‘my experience’ (a prerequisite to individual subjectivity) and to attach positive and negative affective markers to events relevant to an organism's survival. Natural selection evolved cortical sculpting and psychological defenses to protect the affective core of the self at whatever cost because proper functioning of the embodied self is essential to species survival. In a neuropsychanalytic conception, a need to preserve the integrity of the self in the face of potentially overwhelming trauma-related affects drives some victims of adversity to construct delusional worlds that provide an illusory respite from a consensual reality they cannot abide.

NEUROPSYCHOANALYTIC CONCEPTIONS OF THE MIND AS A SELF-ORGANIZING SYSTEM

Friston characterizes living organisms as *self-organizing systems* that inevitably differentiate *system* from *not-system* across a boundary mathematically definable as a “Markov blanket” (Friston, 2010). Self-organizing systems strive for an increased automaticity that diminishes *free energy* (reduces surprise). As self-organizing systems, human beings have evolved a physiology that automatically maintains the homeostatic set points of temperature, pH, oxygenation and nutrition needed to sustain life (Damasio & Damasio, 2024). Equilibrium is ensured by extruding toxins and importing needed substrates across the boundary of the cell membrane. Similarly, the mind maintains conscious affective homeostasis via psychological defences (in psychosis, primarily *denial*, *splitting* and *projection*) that extrude toxic mental elements outside what psychoanalysts call the *ego boundary* (Solms, 2021; Tausk, 1988). This perimeter consists of an array of psycho-physiological processes that differentiate mental representations of self from not-self, a function that allows parts of the mind to be disavowed by locating them in mental representations outside the psychological boundary of the self; i.e., this mental content is “not me.” I do not intend comparisons of the *ego boundary* with a cell membrane as a mere metaphor but rather as a literal description of a readily observed psychological process driven by a person's need to modulate the conscious experience of affect. For example, a psychotic man who longs for the life that others lead might rid himself of his jealousy by projecting these feelings outside himself into his mental representation of a shadowy group of saboteurs who envy his genius. In his delusion, it is not he who feels envy, but rather the saboteurs. Instead, he feels admired.

A central operational driver mediating between trauma and psychosis is the inherent tendency of the mind as a self-organizing system to use psychological defences to preserve a stable and coherent sense of self while maintaining affective homeostasis. Affect and emotion are related terms, sometimes used interchangeably, but in general, the term *affect* refers broadly to a feeling state present in the background of experience characterized by a positive or negative valence experienced at varying levels of intensity of arousal. Emotions are subjectively distinct types of conscious affective experience, such as fear, anger, lust, tenderness, anxiety and grief that typically emerge in reaction to life events. See Panksepp for his description of seven types of emotional experience in mammals that motivate behaviour, including SEEKING, RAGE, FEAR, LUST, CARE, PANIC/GRIEF and PLAY that are grounded in different areas of the brain (Panksepp, 2005). By affective homeostasis, a principal metric in the mind's being a self-organizing system, I mean the maintenance of the balanced functioning of the affective system as a whole within an adaptive range, in which the background affective valence remains predominantly positive and levels of arousal remain at functional levels, neither flat nor too intense, allowing differentiated emotions to serve as adaptive alerts.

A psychodynamic defence is a mental activity that shapes the conscious experience of thoughts, feelings, fantasies and memories with the aim of maintaining affective homeostasis within an adaptively functional range. Too much affect overwhelms a person's capacity to think; too little provides insufficient motivation to think. There is an affective “sweet spot” in between. This process resembles how individuals in biofeedback sessions use a computer display of their heart rate and blood pressure to guide their physiology toward a goal, without conscious awareness of the neural route they are following. A

similar process likely underlies psychological defences that guide the mind to an adaptive affective set point.

Individuals with trauma histories who suffer psychoses have typically experienced intense states of terror, rage, loneliness and despair (Garfield, 2009), emotions that are difficult to attenuate except by the radical means of psychotic symptoms, which maintain affective homeostasis in several ways: (1) by falsifying the patient's perceived experience of a painful reality; (2) by locating mental elements toxic to the self (unacceptable thoughts and feelings) outside the psychological boundary of the self in mental representations of other persons and things; and (3) by constructing delusions that create a fanciful narrative, painful as it may be, that sidesteps an unbearable reality of abuse. Sally, as noted above, and delusional patients like her, create stories in which the mind tunes itself to homeostatic need rather than historical truth.

Clinicians who have not experienced situations in which they “almost lost their minds” in response to a devastating event may find it difficult to believe that unbearably traumatic events could be sufficient to precipitate a psychosis. After all, delusions inevitably compound a person's suffering. Nevertheless, a delusion can make the difference between a mental life that cannot be endured (one that may lead to suicide) and a life that will be endured, though with enormous pain. It may seem counter-intuitive to imagine that a disturbing psychotic symptom constitutes a defence, but a traumatized girl likely prefers an abusive disembodied voice to recalling the details of being raped by her father. The choice before the mind is between very bad (the psychotic symptom) and even worse (the memory). Key to a neuropsychanalytic self-organizing model of the mind is the assumption that affects are not simply downstream by-products of biology and cognition, but rather are meaningful alerts, conveyed via consciousness, that drive adaptations to experience (Panksepp & Biven, 2012). The themes of delusions often mirror the patient's traumatic history because in essence, delusions represent disguised remembrances of trauma that cannot be spoken about directly. From this vantage point, delusions persist not so much because of absent belief re-evaluation cognitive machinery, but because the delusion, which has a deep tap root reaching into the patient's traumatic past that is not easily pulled out, provides an explanation of the patient's sorrows that the psychotic person is loath to abandon. Once a person has already expended their meaning making all in desperate conditions, already done the best they can to explain their sorrows, they are reluctant to abandon the solution they first arrived at trusting that they can come up with a better idea if they just try again.

THE NECESSITY OF REMEMBERING AND THE MODULAR ARCHITECTURE OF MEMORY

Consistent with the original dictum of Freud and Breuer that ‘Hysterics suffer chiefly from reminiscences’ (Breuer & Freud, 1895, p. 95), psychotic symptoms can be seen as composed of disguised reminiscences of trauma. The human brain evolved with an imperative to remember its sorrows. In the first place, any mammalian species that did not remember and learn from adversities would be doomed to extinction. Second, the imperative to remember trauma is deeply ingrained in human psychology because the realities of life, including its sorrows, are the foundation of authenticity. Few people hope their epitaph will read, ‘Here lies Jethro, who never lived authentically’. Third, we cannot seek another's consolation in the face of our tribulations unless we remember what has happened to us and can speak about it. Instead of being remembered directly, trauma is remembered indirectly in themes that mirror a person's trauma history, a compromise between the necessity of remembering and the wish to forget one's traumatic past.

Neurobiology and experimental psychology have shown that human memory is composed of multiple semi-independent modules that archive different aspects of an event. The brain remembers by *recapitulating* (reactivating) the same synaptic firing pattern that occurred in different memory modules at the time the event was first encoded (Carter et al., 2019). A trauma flashback is a particularly intense involuntary form of recapitulation. This multi-modal structure allows people to

balance remembering and forgetting by recalling some aspects of an event while forgetting others. The operative question is not whether people must remember their traumas but what form that remembrance will take. In PTSD, trauma memories are recalled in flashbacks. In dissociative identity disorder (DID), they are diverted to altered self-states. In psychosis they intrude as anomalous perceptions and flashback-like memories (Hardy, 2017) and they rise to consciousness disguised in delusional narratives that echo themes of the patient's painful history. Trauma traces also endure in seemingly bizarre body-based delusions to which a trauma link may not be immediately apparent, a form of recollection I address later in this paper.

Nine semi-independent memory modules have been identified. They include, with some overlap, *declarative autobiographical episodic memory*, which pictures a life event in place and time; *sensory memory*, which records the sights, sounds and other sensory components of an event; *emotional memory*, archived by the amygdala; *somatic memory*, which records bodily sensations; *gist memory*, which instantaneously distills the essential meaning of an event; *context memory*, which records the background of an experience that can later function as a symptom trigger; *association* and *priming memory*, stored in a matrix of neural connections activated by experiences linked to past events, including trauma; *semantic memory*, in which episodic memory is translated into beliefs about the self and the world; and *non-declarative implicit behavioural memory*, which records procedural knowledge of motor tasks (Squire & Wixted, 2011). Episodic memory is the most fragile type, the most prone to forgetting and revision (Markowitsch & Staniloiu, 2023). A person might recall a trauma in modules other than episodic memory without knowing that they are remembering a past event (Jacoby & Witherspoon, 1982); e.g., a trauma might be re-experienced as a pervasive feeling of fear rather than a discrete memory.

Dissociation as defined by standardized scales such as the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) includes such experiences as gaps of attention and memory, discontinuities of behaviour, depersonalization and derealization, difficulty distinguishing among reality, dreams, imagination and hearing voices. Dissociation has been identified as a mediating factor linking trauma and psychosis (Bloomfield et al., 2021). In the BASK model, Braun (1988) offers a different conception of dissociation in which four components of experience that are ordinarily integrated—behaviour, affect, sensation and knowledge (BASK)—become detached from each other in dissociative splits that fragment the interconnected wholeness of experience; e.g., a person might dissociate affect and feel numb while recalling a trauma (*la belle indifférence*). If one understands the mind to be a self-organizing system that aims to maintain affective homeostasis, then any mechanism that breaks up a disturbing experience or traumatic memory into fragments maintains affective homeostasis by detaching the experience from a complete who-what-where-when record, making the memory less recognizable and therefore less painful. Dissociation pixelates experience by deleting modular elements of memory, decontextualizing fragments of memory, and disguising trauma by projecting its theme into a delusional narrative. In this case, we might say that *dissociation, broadly defined*, is a fundamental underpinning of psychological defence in both psychotic and non-psychotic disorders.

THE CBT_p-G MODEL LINKING TRAUMA WITH INTRUSIVE PSYCHOTIC SYMPTOMS

Hardy's cognitive model (Hardy, 2017) links trauma-related intrusions in psychosis to PTSD flashbacks, underscoring the role of trauma in psychosis. Her paradigm, which traces a pathway from reactions to trauma to intrusive experiences, focuses on episodic memory, perceptual memory and semantic memory. She cites Brewin (2014) who divides the trauma trace in PTSD into 'S-reps' that encode the sensory components of the trauma memory and 'C-reps' containing a conceptual representation that can potentially be verbalized and connected to a traumatic event episode. In PTSD flashbacks, S-reps dominate C-reps, recapitulating the sensory component of the original trauma. The following case example adds *associative* and *priming* memory (Westen, 1999) to the three modules noted by Hardy.

Clinical case 2

Maya, whose psychotherapy I supervised, was a middle daughter born to parents in the diplomatic corps whose international assignments caused her to live through the disruptions of three different schools by the time she was 10. She reported that when she was 'little' her father came to her bedroom at night and touched her 'privates'. When she told her mother about the molestation, her mother called her a 'wicked girl' for making up such stories. She told her clinician that she had dropped out of college to pursue the more important goal of working with the President and First Lady to expose a paedophile ring in her neighbourhood. She lived in a constant state of fear but was nevertheless determined to bring the paedophiles to justice. She claimed to have a sixth sense that allowed her to identify abusers. Her job was to watch and report her observations telepathically to White House officials. She interpreted ambulance sirens as warnings sent by the White House that paedophiles might be nearby. At night, she heard a derisive voice calling her a 'slut', and she occasionally heard footsteps in the hallway that warned of an intruder. She sometimes awoke with a telltale sensation in her genitals indicating that she had been drugged and raped as she slept. Neuroleptics marginally allayed her fears during the day but had minimal impact on her delusions or voices.

The diversity of Maya's psychotic symptoms can be mapped onto the modular architecture of ordinary memory, a spreading out of the trauma trace that conceals its true origin. Owing to biological disturbances in encoding and recall and to her psychological resistance to remembering, buttressed by her mother's denial of her abuse, she remembers her trauma in a fragmented, displaced, disguised fashion that in her delusional narrative restores her affective homeostasis. The paedophile ring she wishes to bring to justice is a disguised mental representation of her abusing father and complicit mother. In her story, the President and First Lady are the caring parents she never had. As a paedophile investigator, she is not helpless and hopeless. With the aid of idealized parents, she will stop the perpetrators from harming other children, with whom she identifies, and bring the paedophile ring (her parents) to justice. The footsteps in the hall echo a *sensory memory* of her father's approach (Ellenson, 1986). Her genital sensations are fragmented *somatic memories* of being touched in her 'privates'. Her pervasive fear likely builds on an *emotional memory* of her constant anticipation of her father's assault. The denigrating voice is a decontextualized auditory expression of her self-hatred, her feeling that she is a 'wicked' girl responsible for her abuse. And, an *associational memory* network *primed* by her abuse fires at the slight provocation of a distant ambulance siren, which she takes to be confirming evidence of the omnipresence of the White House team and the abusers.

The feeling of 'nowness' that is characteristic of PTSD and PTSD-like intrusions in psychosis occurs in ordinary mental life in 'flashbulb' memories in which people recall where they were and what they were doing when they learned of a major disaster (Brewin, 2014). This phenomenon marks 'nowness' as an expected attribute of all intensely distressing memories. Hallucinations and delusions are experienced as happening in the present with an insistent 'nowness', but because psychotic symptoms are not generally viewed as disguised trauma traces, clinicians typically interpret the 'nowness' of psychotic symptoms as a lack of insight rather than as the 'nowness' of disturbing memories. If we regard psychotic symptoms as disguised trauma traces, and we regard a chronic delusion as a protracted form of traumatic reminiscence that is semantically elaborated in a delusion, PTSD and chronic psychosis can be viewed as different phenotypic reactions to trauma. Why one person develops PTSD and another becomes psychotic likely depends on a host of biological, social and psychological variables, all needing more research.

In my view, the Hardy model offers a strong account of trauma-memory intrusions in psychosis. The model proposed by Garety and colleagues (Garety et al., 2001) in which past learning and personality, current information, information-processing style and high arousal lead to delusional beliefs, provides a comprehensive account of cognitive processes in delusion formation. A neuropsychanalytic model adds to these hypotheses a person-specific understanding of the origins of the cast of delusional characters and narrative themes that abound in delusions. CBTp-G inclined readers might consider the neuropsychanalytic model outlined here to be a particular elaboration of the past learning, personality and high arousal components in the Garety overview.

A NEUROPSYCHOANALYTIC OBJECT RELATIONS MODEL LINKING TRAUMA AND PSYCHOSIS

I now sketch a neuropsychanalytic model of the developmental path that a trauma trace might take from early childhood to psychosis in adolescence. This model emphasizes early *attachments* (Bowlby, 1983), arguably the most research-tested tenet of psychoanalytic theory. In normal development, beginning in infancy, mental representations of relationships with caregivers are preserved as an *implicit behavioural knowing* that offers a template for interactions with others (Bowlby, 1983; Lyons-Ruth et al., 2006; Main et al., 1985). These templates are procedural guides (rather than semantic rules) that provide the scaffolding upon which children organize their relationships. Psychoanalytic object-relations theory (Kernberg, 1976) holds that by 18 months before the child is able to verbalize their content, these templates give rise to intra-psychic mental representations of others and of relationships (Isaacs, 1948) which take the form of object-related fantasies structured as a self-representation envisioned in relationship to an object-representation, linked within an affective valence (Kernberg, 1976). An internal *object* is not a physical thing but rather a mental representation of an object of interest or concern. In a securely attached child, the primary internal object relationship is the dyad of self and caregiver, bound together with a loving affect. By age 4, the episodic memories that chronicle the child's narrative self (Stern, 1985) and the child's semantic memories (beliefs) about self and others have been shaped by three elements: object-related fantasies, naïve cognitions appropriate to the child's developmental level and the child's accurate perception of some aspects of reality (Erreich, 2015).

TRAUMATIC MEMORIES IN NORMAL CHILDREN

Typically, young children retain highly accurate implicit non-verbal behavioural memories of traumatic experiences (Gaensbauer, 2004). The case of 'Little Betsy', whose trauma was unrelated to relational abuse, illustrates the evolution of a trauma trace from early childhood (Coates, 2016). When Betsy was 10 months old, she was viciously stabbed in the abdomen by a deranged man in a public park. One day at age 3 when in the kitchen with her father, standing on a chair so that the sink pressed on her abdominal scar, she said, 'My line hurts!' She then made violent slashing gestures towards her abdomen and said, 'That was a very bad day'. She had preserved an implicit behavioural memory and an emotional memory of the event lacking in episodic detail. At age 4½, she added a semantic elaboration to her behavioural memory. She 'recalled' that her entire family had been with her in the operating room and that her baby sister had stayed in bed with her at the hospital. Betsy's mind, operating as a self-organizing system intent on maintaining affective homeostasis, created a trauma narrative in which she was always surrounded by her loving family. Delusions serve a similar revisionist purpose.

At age 9 Betsy attended a Halloween party at a haunted house where she saw a scary figure in a darkened room holding a knife, which precipitated a severe panic attack. In addition to the accurate behavioural memory that she later semantically elaborated, her trauma primed a network of associations to men with knives, that led her to relate the Halloween figure to her original attacker. Her history illustrates how episodic details are lost or revised, while the trauma is otherwise accurately recorded in one or more different memory modules. A similar sequence can occur in psychosis where not only fragmented episodic, sensory, semantic and associational/priming memory may intrude as psychotic symptoms but also as *implicit behavioural memory*. For example, Karon describes a psychotic man who, like Betsy, retained a clear implicit procedural memory of his mother's choking him for minor offences, a behaviour that was enacted in his psychosis in the symptom of his choking other patients (Karon & Vandenbos, 1981). When Karon helped him recall the episodic context for his implicit behavioural memory, his attacks on other patients stopped.

THE INTERNAL OBJECT-RELATED WORLD OF CHILDREN WHO HAVE BEEN ABUSED

Even securely attached children of loving caregivers may fear the proverbial monster under the bed, but over time, well-parented children outgrow such phantoms of their imagination. In the case of abused children, the monster is a reality, not a fantasy. Children fear their abusers, but their need for comfort, their dependence on the abuser, and the effects of the attachment hormone oxytocin drive them into the arms of the abuser, leaving no possibility of behavioural escape. Unable to flee an external danger, maltreated children flee psychically by reconfiguring their internal world of psychological objects to preserve an image of a loving caregiver necessary for their emotional survival. The impossibility of reconciling a needed caregiver and an abuser results in a splitting of mental representations of self and others into 'all good' and 'all bad' images (Liotti, 2006), a split Teicher et al. suggest may be facilitated by trauma-related brain changes in the corpus callosum (Teicher et al., 2016). The child in effect imagines the caregiver alternately to be two different people, at times a 'good' mother the child needs to believe in to feel safe, and a different terrifying 'bad mother' present when the child is being abused (cf. the wicked witch of fairy tales). This internal split between all-good and all-bad images can be observed in the behaviour of children with a disorganized attachment style, a style overrepresented in individuals with psychosis (Bucci et al., 2017; Harder, 2014), in which a child alternates between approaching and avoiding the caregiver. This splitting shapes the unconscious content of the psyche, resulting in fragmented images of the self and others; i.e., a devalued self-representation assailed by persecutory objects that are stand-ins for the child's abusers, and an omnipotent self-representation that in fantasy denies the child's dependency needs, which in psychosis may fuel delusions featuring a grandiose self in congress with demeaned others.

Although some abused children develop psychotic symptoms in childhood, typically psychosis does not emerge until adolescence or young adulthood, when one is expected to establish relationships outside the nuclear family. Adolescence is the test of all previous development. Lacking self-esteem and trust in others, abused children are ill-prepared to meet the developmental challenges of their teen years. Social failures accumulate. Fear, anger and despair revive the affective memory of their traumatic past, causing at-risk adolescents to feel fear that builds upon a remembrance of childhood trauma. Anxiety overwhelms coping capacity. The subliminal trauma trace of abuse shapes the adolescent's experience of the present, which activates (recapitulates) associational, contextual, emotional and sensory memories of trauma that come to consciousness disguised in psychotic symptoms.

A psychosis ensues, resulting in hallucinations and delusions that echo the narrative of the person's trauma, and in altered subjective states that in two-factor neurocognitive models of psychosis are framed as anomalous perceptions (Coltheart et al., 2011). Fuelled by the psychic pain that animates them, persecutory and grandiose internal objects originally formed in response to abuse, latent since childhood, rise up and fuse with the adolescent's mental representations of self and others. The mind effectively turns inside out. Persecutory object-related fantasies become perceived reality. Individuals suffering psychosis 'see' evidence of a persecutor that they expect to perceive or 'hear' the self-hatred of an abused child in a derogatory voice. This falsification of reality, which reinforces delusional conviction and breeds more trauma, leads to a host of delusional misconceptions; e.g., 'Hackers violate my privacy online as abusers violated me when I was a child'. Or, 'The villains who claim to be my parents kidnapped me from my real parents, who love me and are trying to find me', and so on, to the limits of the person's imagination. Because the childhood trauma trace was never worked through, when it is revived in adolescence, it persists like a flashback that never ends. See Figure 1 for a summary of the developmental progression from trauma to psychosis.

Although the significance of affect in the inception of psychotic symptoms was noted early in the development of CBTp-G (Freeman & Garety, 2003) and although affect was later incorporated more generally in the 'CBT triangle' of cognition, behaviour and emotion, cognition rather than affect remains the cornerstone of cognitive-behavioural theory and practice. However, if one grants affect a primal role in object-related fantasy and delusion formation, a number of considerations fall into place.

Trauma and Persecutory Internal Objects	Adolescence	Developmental Failure	Psychosis
Physical and/or sexual abuse and emotional neglect in childhood leave an indelible imprint in the developing child's psychological world. Abused children internalize mental representations of their abusers in object-related fantasies (core schema) of the self in relationship with persecutory objects. This template colors all subsequent interpersonal relationships.	As latency-age children enter adolescence, they are expected to be increasingly independent, relying on peers to provide satisfaction and self-esteem outside their nuclear family. Full of fear, mistrust, and self-doubt, adolescents who were abused as children are too psychologically damaged to successfully achieve the developmental milestones of adolescence.	A mounting sense of failure and futility ensues. Assailed from within by the impossibility of integrating their childhood trauma into a confident sense of self and confronted from outside by social demands they cannot meet, the person's mind falls apart into fragments modelled after the persecutory objects laid down in childhood, which are then projected into the patient's experience of the real world.	The psychotic young person substitutes an illusory reality for a consensual reality in which they cannot find a place for themselves. Their falsified reality is held together by a delusion that contains dissociated trauma memories and delusional characters that enact themes that mirror the patient's trauma history. The delusion attempts to maintain affective homeostasis by providing an explanation to the patient of their sorrows.

FIGURE 1 An object relations perspective on development from child abuse to psychosis.

For example, instead of conceiving of ‘inappropriate affect’ or maladaptive ‘emotional thinking’ in psychosis, one might view all emotions as commensurate with the fantasies that underlie them. And as noted earlier, instead of conceiving of the persistence of delusions as reflecting an enduring cognitive deficit, one might regard this persistence as a person's desperate attempt to maintain affective homeostasis. Shifting focus to affect can have practical clinical implications. While not agreeing with what the patient *believes* (cognition), the patient and therapist can often agree about what the patient is *feeling*, which fosters engagement and the therapeutic alliance.

OUR NARRATIVE UNDERSTANDING OF OURSELVES AND OUR INTERPERSONAL WORLD

Bruner (1991) notes that an understanding of physical reality can be achieved with what he calls a ‘paradigmatic mode’ of thinking in which the objective properties of the world can be measured, the basic method of experimental science. When it comes to understanding the motives of other people, because we cannot access their thoughts and feelings directly, we must *infer* the reasons they act as they do. We have no recourse but to rely on a narrative understanding of our interpersonal field, which Bruner calls ‘narrative mode’. For example, a person might offer a cause-and-effect explanation of another person's behaviour at a social gathering. ‘When he saw me, he walked away because he felt guilty about the way he treated me the last time we met’. This narrative may or may not match the account of the person who walked away. The truth of a narrative always depends on the point of view of the storyteller. It is never an invariant given. A shared understanding of subjective experience must always be negotiated between interlocutors. Psychotherapy allows patients and clinicians to negotiate the narrative truth expressed in a delusion. When a biologically committed prescriber adopts a narrative that views hallucinations as a genetically determined aberration, there is little if any ground for a ‘negotiated’ understanding of a voice as a de-contextualized trauma trace.

Because abused individuals who become psychotic cannot tell the truth of their lives in a straightforward historically accurate narrative, they tell their story in disguise. Delusional narratives constitute an *autobiographical play staged in a person's mind, inside the person's body, and/or in the outside world with a cast of characters drawn from the afflicted individual's internal object world that enact a story depicting the patient's fundamental psychological concerns*. Center stage is not a brick-and-mortar theatre but typically the person's room or

immediate neighbourhood. The play is a compromise formation that fulfills the necessity of remembering trauma while disguising what is too painful to directly recall. The play manifests, chronicles, invites witness to and depicts a person's life history in the play's characters and story line while modulating painful emotions attached to the adverse life experiences represented in the story (Garrett, 2019). As noted above, psychotic symptoms mirror a patient's trauma history because they are the patient's trauma history, rendered in disguise.

I am not saying here that a delusion is *like* a play but that it *is* a play, a particular kind of play, written by the patient 'playwright' who does not know they have written a play. Patients speak to the essential truths in their lives through a cast of characters, some based on actual people, some imagined, that interact in a delusional plot line that mirrors their history. These characters are drawn from the archetypal 'all good' and 'all bad' characters that in ordinary mental life populate fairy tales, parables and fables. Karpman describes a 'drama triangle' that structures dramatic narratives in commercial fiction that includes a persecutor, victim and rescuer role. Whereas in fairy tales and fables, the persecutor role is played by a witch, an ogre or an evil gremlin, in paranoid delusions, the abuser of childhood is typically cast as a persecutor imagined to be the Devil, a government agency or a neighbour.

BODY-BASED OBJECT-RELATED FANTASIES

As noted above, psychotic symptoms may contain de-contextualized fragments or narrative themes that clinicians can easily relate to the patient's trauma history, as in the cases of Sally and Maya above. Trauma may also be represented in seemingly bizarre *body-based fantasies* that at first appear to have no relationship to childhood adversity but nevertheless tell the patient's trauma history. Psychoanalytic theory posits that in a child's earliest fantasied conception of what goes on in interactions between the child and other people, the child imagines that the relational exchange involves one person putting something into the body of the other. Although space does not allow even a modest explication of the role of body-based fantasies in ordinary mental life and psychosis, brief mention of experimental evidence for the existence of such fantasies in ordinary people must suffice, fantasies that are writ large in psychosis.

Roughly 50% of educated adults understand vision as a process of 'extramission' in which a substrate is thought to flow out of a person's eyes, interacting with the perceived object (Winer et al., 2002). This belief articulates a primal (developmentally early) object-related fantasy that construes vision as the seer putting something into the perceived object. This fantasy features in the not uncommon delusion that a persecutor has penetrated the patient's body with their glance or their brain with a computer chip. Similarly, experimental psychology confirms what has been called 'the Macbeth effect'. In an experimental protocol that invites subjects to contemplate examples of immoral behaviour, when subjects are offered a gift thanking them for their participation, they show a preference for cleaning products over gifts of other sorts, revealing a wish to physically cleanse themselves of tainted memories and thoughts (Zhong & Liljenquist, 2006). These experiments expose a body-based, object-related fantasy that imagines that immorality attached to the skin can be physically washed away. This idea might appear in a delusional conviction that a minor facial blemish marks the patient as a sinner, or as it did in a patient who imagined that his heart, liver and intestines had been enveloped by a cancer instigated by his mother's touch.

Clinical case 3

A young woman whose treatment I supervised said she had recently travelled to another planet where a girl who looked very much like her was being held hostage in anticipation of the patient's 'switching' bodies with the abducted girl, a process that would afford her a new 'clean body'. Despite adequate personal hygiene, she insisted 'my skin and coochie are filthy'. She expected to exchange her body, including all her internal organs. After developing trust in the clinician, she divulged what the therapist

had suspected: that she had been sexually abused. Beginning at age 6, her father insisted that she watch pornography with him and masturbate herself. She was also sexually abused by her older and younger brothers. To regain affective homeostasis, she created a delusional narrative. Her wish to acquire a new body reflected her wish to start over with genitals unsullied by abuse. The kidnapped girl is a repository for the contaminated body she hopes to jettison, a split-off mental representation of her degraded self. See Hinshelwood for an extended treatment of primitive body-based fantasies (Hinshelwood, 1994).

PSYCHOTHERAPY FOR PSYCHOSIS: POSSIBLE NEXT STEPS

CBTp-G has for decades led the effort to provide psychotherapy to psychotic patients in public sector psychiatry and will likely continue to do so. As for next steps in the development of psychotherapy for psychosis, psychoanalytic psychology may have a role to play in improving care, particularly for patients who fail to respond optimally to CBTp-G methods. *Schema therapy* for psychosis provides an interface where psychoanalytic theory may have something to add to CBTp-G practice. This juncture point is not surprising given that Young et al. (2006) acknowledge that psychoanalytic ideas contributed to the development of *schema therapy*, which they define as a blend of elements from cognitive-behavioural, attachment, Gestalt, object relations, constructivist and psychoanalytic schools. Space allows only brief mention of how psychoanalytic object-relations theory and *schema* therapy might be mutually enhancing.

SCHEMA THERAPY FOR PSYCHOSIS AND PSYCHOANALYTIC OBJECT-RELATIONS THEORY

In his book jacket endorsement of *Schema Therapy Adapted for Psychosis and Bipolarity* (Rhodes & Vorontsova, 2025) Jeffrey Young describes this volume as the first book to apply *schema therapy* to psychotic patients. Rhodes and Vorontsova focus on a variety of self-state modes, including child modes (vulnerable child, angry child, impulsive/undisciplined child and healthy child); parent modes (punitive and demanding); and maladaptive coping modes (compliance/surrender, detached protector and over-compensator). More generally, a *schema* might be defined as an abstraction of the most salient characteristics of a relational experience rendered as a broad pervasive theme or pattern imposed on reality that is comprised of memories, emotions, cognitions and bodily sensations regarding oneself in relationship to others (Rhodes & Vorontsova, 2025; Young et al., 2006). Seen from a CBTp-G vantage, a psychoanalytic object-related fantasy (as defined earlier in this paper) is a type of *schema*. Seen through a psychoanalytic lens, multi self-state *schema* modes represent *splits* in the psyche that result in mental representations (internal psychological objects) depicted in internal object-related fantasies that the patient might engage in an imagined dialogue.

Although there is significant overlap between *schemas* and object-related fantasies, there are significant differences. The following reflections are offered not as a definitive statement of similarities and differences but as an invitation to a conversation between CBTp-G and psychoanalytic clinicians. *Schema* modes are modelled after types of human interaction readily observable in the real world that are naturally open to empathic understanding. For example, most people find it is not a great empathic challenge to imagine a vulnerable child interacting with a punitive adult. By contrast, internal object-related fantasies, although they express relational themes, are not bound by any readily imaginable interaction between people. Rather, they are restricted only by the limits of a person's imagination, untethered by consensual reality. A fantasy may place a patient in relationship to a deity, a supernatural being, part of their own body, an inanimate object, or even an abstraction, forms of relatedness not easily captured by traditional *schema* modes grounded in empathically accessible conceptions of relationships. Rhodes and Vorontsova make no claim that all patients can engage in *schema therapy*, but the clinical examples they offer show that some patients may respond well to *schema* work without the necessity of directly

addressing the content of the psychotic narratives linked to trauma. Such patients appear able to engage the emotional base of the psychosis in a dialogical technique (e.g., the patient talking to their vulnerable child) without the necessity of directly examining the particulars of the delusional narrative.

Assuming that *schema* therapy for psychosis finds broader application in coming years, as it likely will, object-relations theory has a contribution to make to this developing paradigm. Although some patients may be able to fill out *schema* questionnaires and see self-state modes as parts of themselves, a second group of patients may remain doggedly invested in the details of their delusional narrative that contains elements that are, in the patient's view, decidedly not self. This group poses a challenge to *schema* work. Patients who are amenable to *schema therapy* based on readily recognizable interpersonal patterns might be called *empathically near*, meaning that with the therapist's support, they are capable of empathically connecting with part-self modes mobilized by *schema* work. A second group of patients might be termed *figuratively displaced*, meaning that the symbolic (figurative) machinations of their psychotic process have carried them too far afield from familiar empathic ground to meaningfully relate a *schema* questionnaire to themselves. In the *figuratively displaced* patient, the patient's trauma history and associated emotions are buried (disguised) in their delusional story where these parts of self are experienced as alien, outside the boundary of the self, concretized beyond the patient's capacity to empathically connect these projected elements with the self. Said another way, *empathically near* patients can find themselves in a *schema* questionnaire while in *figuratively displaced* patients the self waits to be found in the particulars of the delusional narrative. The following clinical example suggests how an object-related perspective might inform work with patients whose minds are *figuratively displaced* from more familiar empathic ground.

Consider a not uncommon delusion that a computer chip capable of monitoring a person's thoughts has been planted in the patient's brain. I am not claiming that the object-related formulation offered here could never have been conceived by a CBTp-G clinician, only that understanding the psychological dimensions of the chip comes easily in an object-related frame. From an object-related perspective, the patient's relationship with the computer chip does not mirror a relationship with another person that could be readily captured as a *schema* mode. Rather, the patient has formed a relationship with an abstraction (i.e., the capacity for self-reflection) that has been projected into the patient's mental representation of the chip, a formation that Bion called a 'bizarre object' (1957). The chip is an inanimate concretization of the capacity for self-observation, an object-related instantiation of the phenomenon of hyper-reflexive self-awareness, a malignant self-consciousness that often plays a central role in psychotic experience (Sass & Feyaerts, 2024). The patient experiences his relationship to the chip as that of a subject being observed by a passive sensor that does not have the capacity to think, feel or speak, but only to relay information to some monitoring entity. It would likely be difficult to approach the chip in chair work or with another dialogical technique because, despite its centrality in the patient's psychosis, the chip could not reflect upon anything the patient might say because it cannot think. There is no compassion to be found in a conversation with a mute echo machine made of silicon.

Here is a clinical example of an object-related formulation of an embedded chip that was useful in the psychotherapy of a 17-year-old adolescent who as an only child suffered the developmental trauma of the loss of his mother when he was 10 years old. He was raised by a doting aunt who hovered over him to whom he became overly attached. His symptoms are *figuratively displaced* into a relationship with a computer chip and a hallucinated voice. He believed that his thoughts, including his sexual thoughts, were being transmitted by a chip in his brain to a voice he called Psycho Girl, who repeated his thoughts back to him with 100% accuracy, which convinced him that she had the power to strip him of his privacy of mind. The hyper-reflexive field that his mind had become gave rise to personified characters that possess hypertrophic observational capacities. He saw 'signs' that Psycho Girl had, to his shame, revealed his thoughts to his peers and his aunt. He experienced the chip and the voice (he was male and the voice was female) as not-self rather than as a self-state mode. Expressed in object-related terms, the chip is a mental representation of his awareness of his sexual fantasies. He is watching his own thoughts about women, which he finds exciting, but also anxiety-provoking. He must keep his mental representation of the women he is fantasizing about separate from his aunt, the most important woman in his life, because he cannot allow her to know about his fantasies or to become the object of his fantasies.

Accordingly, the observing entity is displaced away from his aunt via the chip onto Psycho Girl, who knows everything he is thinking, which keeps his aunt in the dark about what he is thinking, and preserves his precious relationship to her free of contaminating sexual thoughts.

When asked if there was ever a time he didn't hear Psycho Girl, he said yes. Sometimes when he was caught up in an activity that he found particularly interesting (e.g., reading) he didn't hear her. This led him to conclude that Psycho Girl could not attend to his thoughts when his attention was otherwise preoccupied. At first, he continued to believe that Psycho Girl was an entity separate from himself, but that his paying close attention to something 'blocked' Psycho Girl's powers. Over time in psychotherapy he came to understand that Psycho Girl's uncanny ability to repeat what he was thinking did not arise from a supernatural capacity, but rather that the accuracy of her echoing his thoughts reflected his ability to follow his own thoughts, which of course he could do with 100% accuracy because he was thinking them. Understanding the connection between the chip and the Psycho Girl echo in turn helped him to link the attention Psycho Girl paid to his thoughts to his own guilty awareness of his sexual fantasies, and most particularly, his fear that his aunt might find out that he was watching pornography on his computer. This realization led to a gradual reduction in Psycho Girl's presence in his mind and increased functionality at school.

From an object-related point of view his delusion constitutes an autobiographical play with five characters: (1) his thoughts; (2) the chip; (3) Psycho Girl; (4) his peers; and (5) himself, the thinker of his thoughts. The play is set on an imaginative stage: in his brain, which contains the chip; in his mind, where he hears Psycho Girl; in his bedroom where he has sexual fantasies; and at his school, where he feels shamed by his peers. A clinician familiar with object-relations would find this formulation straightforward. Discerning the meaning of a play, a film, or a work of fiction requires no advanced training. Three-year-olds can understand simple story books. To discern the meaning of the autobiographical play enacted in psychotic symptoms, the clinician must shift gears away from diagnostic classification and learn to listen as one might listen to a play or a work of fiction, expecting that the meaning of the play will be forthcoming if the listener pays attention.

Psychoanalysts are trained to listen to nuances of word choice. Extending the above formulation in a way that CBTp-G clinicians may find too fanciful, one might ask why, out of a long list of other possible choices, does he choose 'Psycho' as the voice's first name? A basic tenant of psychoanalytic theory—psychic determinism—holds that a patient's free associations are meaningful expressions of their psychology rather than random events, an assumption that also underlies guided association and guided imagery in CBTp-G. In a psychoanalytic manner of listening his selection of the voice's name reflects a free associative process that expresses meaning. And so, from an object-related perspective, the question now becomes what part of him has been projected into the Psycho Girl character's first name? 'Psycho' is a denigrating fear-eliciting term for someone who is mentally ill. If one were to ask which character in his autobiographical play is cast as being crazy, it is not him but Psycho Girl, as evidenced by her name. With her and her name, mental derangement enters the play. From an object-related point of view, his calling the voice 'Psycho' reflects a subliminal awareness that he is mentally ill. He attends a psychiatric clinic but protects himself from thinking directly about his being a 'psycho' by projecting his concern about being crazy into the Psycho Girl character. In his story, she holds his awareness that he and other people consider him to be a 'psycho'. This negative self-schema is *figuratively displaced*, buried in the name of his voice. There are of course other associational implications to a 'crazy' girl having taken up residence in his mind.

Here is another example of how free associative listening to particularities of word choice can be useful in work with psychotic patients. I was invited to consult regarding a patient presented for discussion by an early career CBT-G clinician—a hospitalized chronically psychotic man in his mid-50s whose primary symptom was his delusion that the world was about to end, a conclusion he buttressed with weather reports indicating that a 'bad tornado season' was expected in the Midwest. He was cooperative in CBTp sessions, where he examined alternative explanations for the ominous weather reports; e.g., that weather comes in cycles, there had been bad tornado seasons before and the world didn't come to an end. Although he seemed reassured by the CBTp work, every evening he made a panicked phone

call to the local police rescue squad that disrupted the hospital milieu, demanding that they come to the hospital to rescue him. The therapist noted that at these times he repeated the phrase, ‘The police have to come when you call them!’ over and over again, like a mantra, but the therapist (and the therapist's supervisor) made no connection between the patient's frenzied plea and his trauma history. Seen through a psychoanalytic object-related lens, viewing his call to the police as a scene in an autobiographical play, it was possible to discern the meaning of his mantra.

His father had abandoned the family when he was 6 years old. He had witnessed his mother's suicide when he was 17 years old. She had jumped from the roof of their apartment building, impaling herself on a spike protruding from a fire escape. He suffered his first psychotic episode the following week. His older brother, who was then in college, took over his care. He found a single-room apartment near the campus, saw his brother often, and ensured that he kept his appointments at the clinic where he was being treated. The older brother became the sole support for his chronically psychotic younger brother. The older brother, now in his early 50s, burdened by a medical condition and tired after 30 years as a caretaker, mentioned to the patient that he was thinking about moving out of state to Florida, and, anticipating this move, wanted to discuss with the patient his applying for admission to a supervised residence. This discussion precipitated the index admission. The patient buried his terror of losing his brother in a *figuratively displaced* narrative, a one-act play involving the police, who, unlike his beloved brother who was threatening to move away, were dutybound to come when he called, proxies for the loyal brother who had stood by him for so many years. Understanding this dynamic led to staff arranging a regular set appointment late in the afternoon when the patient could speak briefly with his brother, which established enough confidence that he could reach his brother that he stopped making frantic calls to the police.

TRANSFERENCE IN PSYCHOTHERAPY FOR PSYCHOSIS

Another difference between psychoanalytic psychology and CBTp-G technique is the primary emphasis placed on what psychodynamic clinicians call the *transference*, meaning the patient's transfer of thoughts and feelings that were originally directed towards early-life figures onto the therapist. The patient's *transference* casts the therapist in an object-related fantasy that determines how the patient sees the therapist. From a *schema therapy* perspective, *transference* is a form of *schema* through which the patient perceives the therapist. *Schema therapy* focuses on core beliefs about the self and people in the patient's past rather than an analysis of the moment-by-moment manifestation of *transference* towards the therapist that psychodynamic clinicians are trained to make the subject of psychotherapeutic work. For example, a psychotic woman I had been working with for some months observed a single potted plant on my windowsill when she entered my office, a recent gift from a colleague. Herself a gardener, she asked, ‘Why don't you have any other plants? And that one looks like it needs a little water.’ Her noticing the solo plant that she felt needed water surfaced her doubts about my capacities as a caregiver. If I wasn't competent to take care of one plant, how could she count on me to meet her needs? Understanding the transference allowed me to invite discussion of her concerns, which when openly spoken about were, for the time being, allayed.

CBTp-G clinicians may wish to note the transference processes that operate in the patient's perception of the therapist, where individuals with psychosis may regard the therapist as:

- Someone who must solve a pressing practical problem the patient faces before the patient will regard the therapist as a credible helper.
- A saviour who can rescue the patient and provide for all their needs if the patient surrenders to the therapist's will with no requirement to contribute to their own recovery.
- An ally who will fight with the patient against the patient's persecutors.
- A person in authority who can corroborate the ‘truth’ of the patient's story.
- Someone the patient must see for appointments to placate a third party.

Establishing an alliance with a patient who in the *transference* identifies the therapist with a persecutory object can be particularly challenging. Such object-related fantasies may include:

- Someone who will medicate or lock the patient up if they reveal too much.
- Someone has forbidden the patient to speak to the voices.
- A co-conspirator with the patient's persecutors, all the more dangerous, were the patient to trust the therapist because of the therapist's dissembling seeming offer of help.
- Someone who can violate the patient's privacy by reading the patient's mind, effectively repeating prior trauma by 'mind-raping' the patient.
- Someone whose words must not be listened to for fear the persecutor will infiltrate the patient's mind, take over the patient's thoughts and absorb the patient's mind into the therapist's psyche.

These formulations might of course occur to a CBTp-G clinician, but psychodynamic clinicians are trained to listen for the *transference* as though it were a melody constantly playing in the background of the treatment.

One final note about where the experience of the psychoanalytic community might add something to CBTp-G. The STAR Trial currently underway is directed at treating trauma-intrusions in psychotic patients (Peters et al., 2022). Psychoanalysis began with the expectation that helping patients remember their traumas would provide relief, but this hope was soon abandoned (Freud, 1914). In essence, what psychoanalysts found was that the trauma trace was not confined to an episodic memory that could be recalled and 'abreacted' (discharged) but that trauma typically infiltrated the patient's personality as a whole where it could not be dislodged by remembering it. This finding ushered in the era of 'ego psychology' that relied on free association to lead the patient and the analyst to the associational matrix where the trauma had taken up residence in the patient's mind. It remains to be seen whether treatments in the STAR trial will encounter similar limits.

SOME POSSIBLE WAYS TO ENCOURAGE DIALOGUE BETWEEN CBTp-G AND PSYCHOANALYTIC CLINICIANS

1. Convene joint clinical case conferences (likely online) in which senior clinicians of different persuasions offer clinical advice regarding a patient presented to the group.

2. Assemble discussion panels at in-person conferences or online, in which practitioners of CBTp, ACT, compassion-focused therapy, *schema* therapy and psychodynamic clinicians would compare and contrast their approaches, followed by open discussion.

3. Clinicians of different persuasions co-author a paper to compare and contrast approaches.

4. Organize an entire conference with CBTp, ACT, compassion-focused therapy, schema therapy, psychodynamic speakers and, importantly, biologically oriented psychiatrists who provide psychopharmacology.

CONCLUSION

Research in the last four decades has shown a significant correlation between childhood trauma and psychosis, a finding that recasts what has been called schizophrenia as a trauma-related disorder requiring trauma-informed psychotherapy. Psychotic symptoms represent a compromise formation between an imperative to remember traumatic experiences and a psychological wish to forget them. Symptoms allow some recollection of trauma, but in disguise, in the content and themes of delusions and hallucinations. Psychotic symptoms represent the psychotic person's personal best effort to maintain affective homeostasis in the aftermath of trauma. It is apt that neuropsychanalysis contribute to the lead taken by CBTp-G in psychotherapy for psychosis in public sector mental health.

AUTHOR CONTRIBUTIONS

Michael Garrett: Writing – original draft; writing – review and editing.

ACKNOWLEDGEMENTS

Nancy McWilliams, Ph.D. for discussion of content and copy editing.

CONFLICT OF INTEREST STATEMENT

The author has no conflict of interest financial or otherwise related to the publication of this paper.

DATA AVAILABILITY STATEMENT

This paper does not include empirical data. I have no objection to the dissemination of the content of the manuscript in keeping with journal policy.

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How to cite this article: Garrett, M. (2026). Links between trauma and psychotic symptoms: Integrating cognitive behavioural and neuropsychanalytic models of psychosis. *Psychology and Psychotherapy: Theory, Research and Practice*, 99, 301–323. <https://doi.org/10.1111/papt.70029>