Reconstructing and Integrating Psychotic States

Abstract

Background

While contemporary psychiatric nosology has become increasingly subdivided, the boundaries and conceptual relations among diagnostic categories remain insufficiently clarified. This can fragment symptom understanding and make it difficult for patients themselves to situate their own clinical picture within the broader landscape of psychotic states.

Objective

To clarify the continuities and distinctions among schizophrenia, bipolar disorder, depression, and neurosis by organizing them in terms of symptom meaning and psychopathological structure, and to propose an integrative framework for understanding psychotic states with implications for therapeutic direction.

Methods

This is a psychopathological and theoretical investigation grounded in a case description of the author's experience. Based on the author's experience of a psychotic state (including experiences within the schizophrenia spectrum), symptom meaning and psychopathology were described through self-observation and psychoanalytic interpretation and the constructs were reconceptualized in relation to established diagnostic and psychoanalytic concepts.

Conclusions

Delusion was redefined not in terms of truth or falsity (congruence with external facts) but as a mode of thinking and relating generated by a self–other relationality that harms both the self and others. Accordingly, the therapeutic target was positioned not as correction of delusional content but as transformation toward a mutually sustaining self–other relationality. Depression was redefined not as a mere aggregation of symptoms but as an "existential crisis" (loss of a sustaining ground), within which depressed mood, anhedonia, loss of energy, thought inhibition, insomnia, and suicidal ideation were situated as derivative phenomena. Within these redefinitions, similarities between schizophrenia and bipolar disorder were noted, and thought disorder was repositioned as the loss of the "ground of thinking" (the premises of judgment, value criteria, and the framework of meaning-making). In addition, Freud's theory of consciousness/unconsciousness was introduced to elucidate the relationship between neurosis and depression, as well as the linkage between the

proposed delusion-as-harmful self–other relationality and unconscious dynamics, thereby indicating therapeutic implications. Overall, this study presents an integrative framework that links diverse symptoms of psychosis on the basis of symptom meaning and psychopathological structure.

Introduction

In clinical practice, delusion is often defined as "a state of conviction in content that differs from reality", and whether a belief is delusional is frequently judged according to its truth or falsity (i.e., its congruence with external facts). Although this definition is pragmatically useful, it is difficult to regard it as adequately capturing the essence of delusion.

First, for patients, delusional content is a compelling reality. Even when others indicate that it is "not real", this experiential sense of reality is not easily shaken. A framework that determines delusion by whether it is "real or not" fails to grasp the patient's lived world and lacks clinical validity from the patient's perspective.

Second, a criterion based on congruence with external facts reveals that the diagnostic judgment is contingent on external circumstances rather than absolute. For example, when a patient reports "a listening device has been planted" or "my life is being targeted", judging these claims as "unrealistic" presupposes a particular social environment. In a surveillance state or a conflict zone, however, similar situations can occur in fact; under such external conditions, the same statements would not necessarily be judged as delusional. This demonstrates the instability of defining delusion solely by reference to external facts.

Third, if delusion is defined as an "incorrect belief that differs from reality," therapeutic goals tend to shift toward correcting or negating the patient's belief, thereby moving away from understanding the structure of the patient's lived world. In particular, for a patient in the midst of a delusional state, acknowledging oneself as "mistaken" is not feasible. Within this framework, the patient cannot obtain a viable orientation for engaging in treatment.

For these reasons, judging delusion by its congruence with external facts has theoretical and clinical limitations. To understand delusion, what is indispensable is not whether a belief is congruent with external facts, but rather how the patient relates to reality through a self–other relationality.

This paper does not deny the operational definition of delusion used in clinical practice. Rather, it proposes shifting the focus of essential understanding away from the truth or falsity of the patient's belief and toward how the patient relates to others and the underlying

self–other relationality (e.g., domination, aggression, condemnation, and self-destruction) that structures the patient's thinking and relating.

I. Redefining Delusion

1. Delusion as a Self–Other Relationality that Harms Both the Self and Others

In this paper, we employ the term self–other relationality as a key concept for understanding delusion. Here, self–other relationality refers to an internal (subjective) mode of relating that operates regardless of whether the other exists as an external entity: how one positions "the other" and how one links oneself and the other. This self–other relationality can also be expressed as interpretation and response within actual interpersonal relationships.

Traditionally, delusion has been understood as an erroneous conviction or a distortion of cognition on the part of the patient. In contrast, this paper redefines delusion as a mode of thinking and a mode of relating that arises from and is grounded in a self–other relationality that harms both the self and others. What is crucial is not whether the content is "real or not", but the self–other relationality that harms both the self and others—underlying the patient's thinking—which constitutes the core of delusion.

2. Delusion: Persecutory Thinking and Aggressive Thinking

As typically seen in persecutory delusions and so-called delusions of insignificance, thoughts such as "someone is monitoring me", "people are speaking ill of me", "I am worthless", or "everything is my fault" are all forms of self-harming thought.

Such persecutory thinking is commonly encountered in clinical settings; however, aggressive thinking is in fact inseparable from persecutory thinking, forming its reverse side. In this paper, "aggressiveness" does not refer to moral blame directed at the person concerned. Rather, it is used to describe the dynamics of a self–other relationality that harms both the self and others. Indeed, moral condemnation itself should be regarded as a form of aggressive thinking.

People are highly sensitive to "what has been done to them", yet are often strikingly unaware of "the aggressiveness they exert toward others." When aggressive thoughts and hostile impulses accumulate and begin to operate unconsciously, they may be reversed and be experienced as persecutory delusion. In this mechanism, because the boundary between self and other can become blurred in the unconscious (i.e., self–other undifferentiation), if the person cannot adequately recognize their own aggression toward others, they may attribute

that aggression to others and experience it as if others were attacking them. In other words, delusion is a form of thinking that arises from a self–other relationality that harms both the self and others, regardless of whether it is directed toward the self or toward others, and it is often recognized only as “being the one who is harmed”.

As Klein’s concepts of projection (and projective identification) suggest, this paper emphasizes that when internal aggressiveness is not held and integrated as one’s own, it may be projected into the other, and as a result, it can be experienced as aggression directed from the other toward oneself.

As a concrete illustration of this point, I refer to an experience from my own adolescence. Following an incident in which my appearance was mocked, I gradually began to search for others’ flaws and fell into a self–other relationality in which I inwardly ridiculed others. Aggressive thinking that accumulated unconsciously in this way eventually transformed into a persecutory delusion that “others are ridiculing me”. This experience suggests that perpetration and victimization are not two independent phenomena, but rather that the same self–other relationality—“ridiculing / being ridiculed”—can appear in different directions, toward the self or toward the other. This example is not presented as proof of the theory, but as an illustration intended to facilitate a dynamic understanding. The present case is an autobiographical case vignette; informed consent has been obtained from the author for publication of this manuscript and for its public release under open access.

Below, I refer to Kraepelin’s account as an observation suggesting that a similar dynamic can emerge with a shift in environmental conditions, such that the directionality may change from an outward (other-directed) to an inward (self-directed).

Regarding dementia praecox, Kraepelin noted that a considerable number of cases had their onset under custodial conditions (e.g., pretrial detention, prisons, compulsory workhouses), and he suggested that situational factors involving deprivation of liberty may influence the clinical picture. At the same time, he pointed out that in a substantial number of cases, personality change had already been progressing prior to confinement, and that this may have contributed to outcomes such as crime or vagrancy. Furthermore, Kraepelin wrote that, “On the basis of a prepared ground, what occurs under the influence of deprivation of liberty is chiefly the delusional type, and this deprivation of liberty thus gives the clinical picture at least a distinctive character” [8) pp.235–236].

In this paper, I regard this observation as particularly important insofar as deprivation of liberty can be understood as an environmental condition in which surveillance and restraint persist and outward (other-directed) thought and action are restricted. Under such

conditions, a self–other relationality that harms both the self and others—previously expressed outwardly in interpersonal situations—may become difficult to externalize, be internalized in a self-directed form, and be experienced as persecutory thinking. Kraepelin's description thus suggests the plausibility of this paper's argument that perpetration and victimization can be grasped as two sides of the same self–other relationality.

3. Collective Delusion and Shared Psychosis

Moreover, an approach that determines delusion by whether it is "true or not" can easily invite the misunderstanding that "if one is saying something correct, then it is not delusion." What is crucial, however, is not the content of a thought or utterance itself, but the **self–other relationality** that underlies it. Even if the content is factually correct, if it is grounded in a self–other relationality that harms both the self and others—such as one that seeks to dominate, attack, or condemn others—it can be regarded as delusional thinking.

That the essence of delusion is not "incongruence with reality" can also be understood from the fact that an individual delusion, judged to be incongruent with external facts, can often become "realized." Here, "realization" refers to the fact that a conviction shared within a group organizes judgment and action within that group and, as a result, comes to function as social reality. In other words, even an individual delusional belief can function as an actual social reality within a group once it is shared and accepted by others.

It has been reported that delusions can be transmitted and shared within close relationships, as in shared psychosis (folie à deux / induced delusion)[9]. In this paper, focusing on the structure whereby delusional conviction is amplified within relationality and comes to function as reality, I argue that its scope need not be limited to dyadic or close relationships; rather, it can be theoretically extended to **group-level delusion formation** in society. For example, even phenomena such as war can be understood as a form of collective delusion formation insofar as shared conviction organizes a group's judgments and actions and functions as social reality. Accordingly, a view that defines delusion solely by congruence or incongruence with external facts is unstable as a criterion, given that even delusions that have not yet been "realized" can be shared and come to operate as reality. Moreover, relying on that criterion risks missing the perspective that grasps the essence of delusion as a self–other relationality that harms both the self and others.

The concept of delusion proposed in this paper is broader than conventional usage. Aggressive thinking such as dissatisfaction, blame, and condemnation can also be understood as expressions of the same self–other relationality as persecutory delusion.

Whether such aggressive thinking is externally expressed (e.g., through overt speech) is not the point. What this paper addresses is whether the thinking itself arises from a self–other relationality that harms both the self and others—such as domination, aggression, condemnation, and self-destruction.

As someone who has personally experienced delusion, I maintain that the perspective of understanding delusion as a "self–other relationality that harms both the self and others" has, at minimum, theoretical coherence for grasping delusion from the standpoint of the person concerned.

4. The Recovery Process of Delusion

If delusion is understood as a mode of thinking grounded in a self–other relationality that harms both the self and others, then treatment can be conceptualized not as correction of delusional content but as transformation of the self–other relationality (i.e., internal self–other relating). In this section, drawing on the author's own experience and clinical observations, I organize the recovery process of delusion in a staged manner.

Stage 1: Peak of Delusional Conviction

When delusion is at its height, the experiential sense of reality remains unshaken even if one is told that it is "not real," and others are consistently interpreted as threats to oneself. At this stage, a self–other relationality in which the other is positioned as an attacking entity becomes fixed; as the reverse side of this structure, the person also becomes prone to reacting aggressively toward others.

Stage 2: A Subtle Awareness of Delusional Relationality

Even when delusional self–other relationality is firmly maintained, through small interpersonal exchanges one may become faintly aware of the possibility that others are not necessarily intending harm. Such exceptional experiences still do not suffice to destabilize delusional conviction, yet they introduce a small degree of plasticity into the self–other relationality and become an opening for later transformation.

Stage 3: Weakening of Delusional Relating (Persecutory Ideation Phase)

Conviction in delusional content diminishes, and the one-sided recognition that "others are a threat" begins to waver. In other words, this stage involves a shift from the certainty that "others are always hostile" to persecutory ideation in which "others may in fact not be hostile, yet they still appear to be hostile". At this stage, interaction with trustworthy persons also becomes possible.

In the course of recovery, persecutory content that had previously been contained entirely "in the head" may shift into persecutory interpretations in real interpersonal situations. From a psychopathological perspective, this can be understood as **projection**, in the sense that internal persecutoryness is attributed to interpersonal contexts. This change is not unique to Stage 3; it can occur at various points in the recovery process of delusion.

Moreover, in this paper, differences in intensity—such as whether something is labeled delusion or ideation—are not regarded as essential; both are treated continuously as manifestations of self–other relationality that harms both the self and others.

Stage 4: Recovery of Understanding of Others and Reciprocity

As transformation of self–other relationality progresses, one's understanding of interpersonal relationships expands. With further recovery, one's grasp of interpersonal relationships becomes more attuned to reality, and one comes to understand that both persecutory thinking and aggressive thinking may be present on both sides—those of the person concerned and those of others. Here, "understanding of others" refers to the restored capacity to consider whether a persecutory conviction derives from the person's own self–other relationality (i.e., persecutory delusion), from the other person's self–other relationality (i.e., aggressiveness), or from both.

At this stage, although a persecutory worldview may still remain, the capacity develops to understand one's own and others' psychology from multiple angles and to grasp relationality without absolutizing it. That is, rather than relying on an early "other-image created by the self", interpersonal insight becomes established in real interpersonal situations—namely, the ability to discern how others think and through what dynamics they may influence oneself.

In this stage, utterances and behaviors such as criticism or blame can increasingly be expressed not on the basis of delusional conviction but on the basis of realistic grounds, thereby gaining persuasive force. At the same time, precisely because this persuasive force increases, if such claims are advanced while persecutory delusion remains, there also coexists the risk that they may function as excessive condemnation or aggression and impose psychological burden on others.

Stage 5: Recovery of Interpersonal Relationships and Residual Vulnerability

Most everyday interpersonal interactions can now be carried out without delusional modes of relating. However, in situations in which one feels negated—such as being met with contempt or ridicule—or when domains linked to feelings of inferiority or past experiences of being hurt are triggered, a vulnerability remains in which delusional interpretations are readily reactivated. At this stage, although the underlying self–other relationality has largely

recovered, the former delusional structure can flare up again in specific situations perceived as threatening to the self. As a result, emotional reactions such as depressed mood, excessive anxiety, and irritability are more easily elicited. This stage thus corresponds to a phase in which recovery and vulnerability coexist.

Stage 6: Shift Toward Mutually Sustaining Self–Other Relationality

In the final stage, one no longer interprets others' negative attitudes as personal threats. While taking into account the other person's circumstances and psychological background, one becomes able to explore forms of relationship that are optimal for both parties. Recovery here does not mean the mere disappearance of delusional content; rather, it is a "reconfiguration of relationality" in which others are repositioned not as antagonistic beings but as others with whom a mutually sustaining relationality can be established. In other words, it signifies a transformation from delusional self–other relationality to mutually sustaining self–other relationality (i.e., love-based self–other relationality). Reaching and maintaining this stage is not easy; however, by positioning it as a therapeutic goal, it becomes possible to clarify the direction of treatment.

In this section, I described the recovery process of delusion in six stages. In practice, however, these stages do not proceed in a fixed linear manner; they may move back and forth, and multiple stages may be observed simultaneously.

5. Love: A Mutually Sustaining Self–Other Relationality

In this paper, "love" is not a moral concept in the everyday sense. Rather, it is a descriptive term used here for convenience to articulate a self–other relationality that sustains both the self and others—standing at the opposite pole of delusional self–other relationality (domination, aggression, condemnation, and self-destruction).

Thus far, I have defined delusion as a mode of thinking and relating that arises from a self–other relationality that harms both the self and others. Concretely, this includes hatred, jealousy, ridicule, complaints and dissatisfaction, blaming others or blaming oneself, self-deprecation, and suicidal ideation.

In contrast, what this paper calls "love" refers to a mode of thinking and relating that arises from a self–other relationality that sustains both the self and others, in which others are positioned not as antagonistic beings but as those with whom a mutually sustaining relationality can be established. This is often expressed in forms such as gratitude, forgiveness, compassion, and respect.

Morality and norms, in themselves, are neither delusion nor love. What matters is how they operate within a person's self–other relationality. That is, when morality or norms are used for domination, aggression, condemnation, or self-destruction and function in a direction that brings suffering to oneself or others, they can become manifestations of delusional self–other relationality. Moreover, when others use morality or norms to make the person concerned suffer, this should be grasped not as a delusion on the part of the person concerned but as delusional self–other relationality on the part of the other.

Love is often described as "unconditional love," yet this expression is frequently not an account of the person's subjective experience but a description of outcomes observed from a third-party perspective. In practice, those who are enacting love often do not consciously recognize their own actions as "love."

In this respect, love has an intriguing symmetry with delusion. Just as insight is lacking in intense delusion, in mature love its practice is also often carried out without conscious awareness. Accordingly, it is expressed in a manner that is not accompanied by a sense of seeking reciprocity or self-sacrifice.

However, the lack of self-awareness described in this paper does not mean that love arises merely by chance. Love itself is not something that can be consciously "performed." Yet it is possible to consciously sustain an attitude of wishing to have love—an orientation toward relationality that does not harm either self or other and that seeks to be compassionate. Through processes in which such an attitude is tested and confirmed within relationships with others, one may, as a result, find oneself in an environment in which a mutually sustaining self–other relationality can become established.

The unconsciousness of love will be discussed in detail in Chapter V (the psychoanalytic perspective).

6. Summary

In this chapter, I redefined delusion not as "incongruence with external facts," but as a mode of thinking and relating that arises from a self–other relationality that harms both the self and others.

I further conceptualized the process of improvement in delusion as transformation of self–other relationality and presented a six-stage recovery process.

Recovery, then, does not mean the disappearance of delusional content. Rather, it is a "transformation of relationality" in which others are repositioned not as antagonistic beings

but as beings with whom coexistence is possible. As the point of arrival of such transformation, I positioned a mutually sustaining self–other relationality—namely, what this paper defines as "love." The connection between delusion and depression will be discussed in detail in the next chapter.

II. Redefining Depression

1. What Is Depression?

In the DSM, depression is operationally defined as a constellation of symptoms and has a certain usefulness as a shared language in clinical practice. However, this operational definition readily leads to an understanding of depression as a collection of fragmented symptoms, making it difficult to grasp the core of the person's experience—namely, an **existential crisis** in which the person's self-world (such as the person's identity and a **sustaining ground**) collapses. In this paper, I conceptualize the essence of depression as this "existential crisis" and treat the characteristic features of depression as manifestations that come to the foreground as the crisis emerges in a state of imminence, or as it becomes prolonged. In addition, taking into account that delusion can function as a sustaining ground of existence, I later examine the linkage between the collapse of delusion and depression.

2. The Essence of Depression (Existential Crisis)

Recast in the vocabulary of this paper, the essence of depression is an "existential crisis". Here, "existential crisis" refers to a state in which one's self-world (such as one's identity and sustaining ground) collapses and is experienced as though the self is losing its place in the world.

For example, imagine a situation under the implicit threat of bodily harm, such that unless one can prove one's innocence by tomorrow, one may lose one's life. If escape is impossible and no help can be expected, the person becomes dominated by restlessness, agitation, and fear; despair emerges; sleep becomes difficult at night, and appetite declines. This situation has aspects close to what the DSM terms anxious distress (a state of acute urgency centered on fear, anxiety, tension, and restlessness). From the perspective of this paper, however, it is understood as the existential crisis expressing itself in a form closest to its prototype.

Furthermore, as this state of imminence persists, fear may give way to depressive symptoms—such as loss of interest or pleasure, loss of energy, feelings of worthlessness or guilt, thought inhibition, and suicidal ideation—namely, the features that the DSM lists as

symptoms of depression. This paper positions these features as manifestations that come to the foreground when the existential crisis emerges in an imminent form or in the course of its prolongation.

It should be noted that the features discussed here (e.g., loss of interest or pleasure, loss of energy, thought inhibition, feelings of worthlessness or guilt, and suicidal ideation) can be described under different names depending on the diagnostic category. For example, within the operational diagnostic vocabulary of schizophrenia, these may be described as affective blunting, avolition, thought disorder, or delusions. Furthermore, time criteria in the DSM—such as "two weeks or more"—are useful as operational conditions for ensuring inter-rater and communicative consistency in diagnosis, yet they do not explain the structure of the person's lived experience. From the standpoint of this paper, diagnostic labels such as depression, schizophrenia, bipolar disorder, and neurosis are understood not as mutually exclusive entities separated by categorical boundaries, but rather as a spectrum that is continuous and overlapping.

Accordingly, in this paper, rather than mechanically determining whether "this is depression or not," I prioritize describing what kind of collapse of the person's self-world (such as identity and a sustaining ground)—that is, an existential crisis—the person is exposed to, and how that crisis is manifested as symptoms.

3. Depression as the Loss of Social Sustaining Grounds

However, existential crisis is not limited to life-threatening imminence. Human beings do not exist merely as biological bodies; they are also social beings who constitute the self within relationships with others. Accordingly, even in situations where there is no physical danger, an existential crisis can arise in the same structural form when sustaining grounds that have functioned as one's self-world—namely, roles, affiliations, relationships, work, and frameworks of valuation (e.g., being useful, being recognized, or meeting expectations)—lose their validity.

For example, in so-called empty nest syndrome, in which one develops "depression (i.e., existential crisis)" after a child becomes independent, the role of "mother". which had previously been central to everyday life, becomes vacant; as sustaining grounds are destabilized, anxious distress and depressive manifestations come to the foreground. Similarly, when a person who has lived a work-centered life develops "depression" following retirement, this can be understood as reflecting the collapse of sustaining grounds that had been formed through carrying out one's work. These examples indicate that existential crisis

can arise in the same structural form regardless of the presence or absence of physical danger, as a result of the loss of sustaining grounds.

4. Grandiose Delusion as a Sustaining Ground of Existence

Grandiose delusion is often understood from the perspective of "being convinced that its content is impossible in reality." From the standpoint of this paper, however, its essence lies not in the unrealism of its content but in the way it operates as a self–other relationality centered on self-exceptionalism and a conviction of superiority (i.e., arrogance), lacking compassion for others. The vocabulary used in this chapter is not intended as moral judgment; rather, it is employed to describe the functioning of self–other relationality, including how others are positioned.

That is, in grandiose delusion, others are not treated as beings with reciprocity but are readily positioned as instruments that sustain self-satisfaction and one's sense of superiority. The belief that one is chosen can likewise be understood as one manifestation of delusion, insofar as it places the self above others and entails a perspective that looks down on others as inferior. In this sense, although grandiose delusion takes a different content from persecutory delusion, both share a delusional structure as a self–other relationality that harms both the self and others. Grandiose delusion can also often function as a retreat from difficulties in reality (i.e., escapism).

5. The Collapse of Grandiose Delusion and "Depression (Existential Crisis)"

In this paper, I argue that grandiose delusion (including grandiose fantasy) can function as a sustaining ground, and that its collapse can connect to "depression (existential crisis)". Here, "grandiose fantasy" is not used to draw a strict clinical distinction from grandiose delusion; rather, it is positioned as a phenomenon of the same form as grandiose delusion, insofar as an internal world of self-exceptionalism functions as a sustaining ground.

To illustrate how delusion can function as a "sustaining ground of existence" and how its collapse may connect to "depression (existential crisis)", I describe an experience of my own. In my early thirties, I was working in a university medical department. Having begun to seek a new position in order to return to my hometown, and after securing an offer, I informed the head of the department that I intended to resign. Once this was conveyed to the professor, the interpersonal situation changed abruptly. I was subjected to intense intimidation, and thereafter I fell into "depression".

At the time, I understood, rationally, that "a new position has already been secured, and I

can simply ride out the unpleasantness of the interpersonal situation and move on to the new environment". However, upon reflecting on why "depression" had arisen, I realized that in my daily life I had repeatedly immersed myself in a grandiose fantasy with sexual elements—an internal world in which I was treated as a special being—and had relied on it as a sustaining ground. When confronted with intense intimidation in the interpersonal situation, I was unable to retreat into that internal sustaining ground; imminence emerged with the loss of my self-world (sustaining ground), and this shifted into "depression". In other words, when grandiose delusion functions as a sustaining ground of existence and collapses due to some event, "depression" as existential crisis may arise.

This case does not provide grounds for generalization; it is presented as a case-like vignette intended to describe the structure through which delusion can function as a sustaining ground.

6. The Disappearance of Persecutory Delusion and "Depression"

It is intuitively easy to understand that "depression (existential crisis)" may arise when grandiose delusion collapses. However, when persecutory delusion—something that should be painful for the person concerned—weakens or disappears, how does the person's inner world change? From the standpoint of this paper, persecutory delusion is also, for the person concerned, a "lived world", and its dismantling can connect to an experience of losing one's self-world (sustaining ground)—that is, to an existential crisis.

As a clinical observation that suggests this point, I recount an experience that I heard from a clinician under whom I previously trained. This clinician reported having encountered a small number of cases in which delusions, including persecutory delusion, had largely disappeared, ; in each of these cases, suicide subsequently occurred. Of course, this observation is hearsay, and it does not permit an immediate conclusion of causality. Nevertheless, it suggests at least that the disappearance of delusion does not always mean "recovery", and that when delusion has functioned as a sustaining ground supporting the person's existence, its dismantling may precipitate severe "depression" and suicidal ideation.

This formulation is also consistent with existing research indicating that depression can co-occur at a high rate over the course of psychotic-spectrum disorders, including schizophrenia, and that depression can become clinically significant not only in the acute phase but also in the course of recovery [(12)].

Harrow and colleagues conducted a prospective follow-up study of patients with schizophrenia and schizoaffective disorder, reporting that a certain proportion developed

“full depressive syndromes” during the follow-up period, and further that patients receiving neuroleptics were more likely to exhibit such syndromes than those not receiving them [6]. From the perspective of this paper, while neuroleptics may contribute to the attenuation of psychotic symptoms, when delusion has functioned as a sustaining ground, its weakening can connect to existential crisis and bring depressive manifestations to the foreground. Of course, the study does not directly demonstrate this causal relationship; nevertheless, it suggests that psychotic-symptom fluctuations, when observed in association with neuroleptic use, may be linked to depression.

Berardelli and colleagues further showed, among psychiatric inpatients, that higher levels of insight are associated with increased suicide risk. In the formulation proposed in this paper, an increase in insight may, at least in certain phases, imply a destabilization of the delusional world (sustaining ground). This report therefore suggests a possible linkage between the dismantling of delusion and the emergence of depression and suicidal ideation [2].

At the case level as well, the phenomenon in which depression comes to the foreground during the course in which psychotic symptoms diminish or disappear has long been described as “post-psychotic depression”, suggesting at minimum that “the abatement of positive symptoms and the emergence of depression can be linked within the same clinical course” [11].

7. Dependence and Existential Crisis

Objects of dependence (addiction) are not limited to alcohol or drugs. In addition to behavioral addictions such as pornography, gaming, gambling, and the internet, dependence may also be directed toward a particular other, recognition, status, money, religion, fortune-telling, and similar objects, all of which for the person concerned can function as a sustaining ground. Moreover, even activities that are socially affirmed, such as study or work, can likewise become objects of dependence when they become excessively fixed as supports of one’s self-world.

It is often pointed out that “depression” lies in the background of dependence. From the standpoint of this paper, objects of dependence can function as a “sustaining ground of existence” for the person concerned. Accordingly, the loss of an object of dependence can connect to the experience of losing one’s sustaining ground—that is, to an existential crisis.

In this sense, dependence can both precipitate “depression (existential crisis)” and function as a defense or escape aimed at avoiding “depression”. When an existential crisis becomes unbearable, a person may attempt to cling to an object of dependence as a sustaining

ground.

8. Summary

In this chapter, I redefined depression not as a collection of fragmented symptoms, but as an "existential crisis" in which one's self-world (identity and sustaining ground) collapses. The features characteristic of depression can be understood as coming to the foreground as symptoms when the existential crisis emerges in an imminent form, or as the existential crisis becomes prolonged.

I further focused on the point that delusion can often function, for the person concerned, as a sustaining ground of existence, and showed that the collapse of either grandiose or persecutory delusion can connect to "depression (existential crisis)".

The two redefinitions proposed in this paper provide a framework for grasping delusion and "depression" as interrelated dynamics organized along the axes of **self–other relationality** and **sustaining grounds**. From this perspective, conventional diagnostic labels and symptom classifications become easier to understand when they are grasped not as boundaries of entities, but in the context of "what sustaining grounds were present, how they became destabilized, and how they lost their validity".

In the next chapter, building on this perspective, I describe schizophrenia and bipolar disorder not as mutually exclusive categories, but by clarifying their commonalities and differences and examining how they are interrelated.

III. Schizophrenia and Bipolar Disorder

1. Continuity and Differences Between Schizophrenia and Bipolar Disorder

In clinical practice, schizophrenia and bipolar disorder cannot always be clearly distinguished. In fact, mood symptoms and psychotic symptoms show substantial overlap both conceptually and clinically, making differential diagnosis difficult. Accordingly, a diagnostic borderland (i.e., an area of symptomatic overlap) can arise between schizophrenia and bipolar disorder. Against the background of such clinical continuity, intermediate diagnostic concepts such as schizoaffective disorder have also been used.

Recent large-scale genomic studies indicate that schizophrenia and bipolar disorder share a substantial proportion of genetic risk, and that there is genetic overlap between the two, including a genetic correlation based on shared SNPs (rg). For example, Lee and colleagues

reported a shared-SNP–based genetic correlation of approximately rg ≈ 0.68 between the two disorders [10].

Accordingly, these findings support a view in which the two conditions are understood not as mutually exclusive entities, but rather as sharing a common genetic substrate upon which disorder-specific components of difference are superimposed [5].

2. Commonalities Between Schizophrenia and Bipolar Disorder (A Structural Hypothesis)

It is difficult to conclude that the two are "essentially the same" on the basis of the existence of a diagnostic borderland (an area of symptomatic overlap) and genomic findings alone. In this paper, therefore, in order to understand their interrelationship, I describe a shared feature from the perspective that "**grandiosity functions as a sustaining ground**".

That is, grandiose delusions observed in schizophrenia and manic states in bipolar disorder, while differing in phenotype, may be continuous insofar as a world-configuration characterized by self-exceptionalism and lacking compassion for both self and other can operate as a **sustaining ground**.

In grandiose delusion in schizophrenia, overt mood elevation may not be prominent. Yet, in the person's inner experience, a psychic state close to elation or omnipotence may nonetheless be established. Mood elevation can be understood as something that often co-occurs, albeit with differences in degree.

3. Differences Between Schizophrenia and Bipolar Disorder (A Structural Hypothesis: Inner Fulfillment and Externalization)

The difference between the two can be summarized in terms of where the grandiose world is constituted and to what extent it is maintained through dependence on external reality.

Grandiose delusion in schizophrenia tends to be established as a "fulfillment that is self-contained within an inner world". That is, because the grandiose world tends not to depend strongly on recognition from others or concrete achievements in external reality, a lack of external validation does not lead directly to its breakdown. Of course, when a breakdown does occur, it can connect to "depression (existential crisis)", yet the degree of dependence on external reality is relatively low. Put differently, grandiose delusion in schizophrenia tends not to be mediated by points of contact with external reality (such as others' reactions or social feedback), and for this reason it can be established and maintained even in forms

that deviate from the shared understanding of those around the person.

By contrast, in the manic state of bipolar disorder, the grandiose world tends to be externalized into the sphere of the external world and interpersonal relationships. Because grandiosity is maintained through interactions with external reality—such as social activity, interpersonal relationships, and evaluation—realistic constraints and interpersonal friction are more likely to precipitate the breakdown of the grandiose world (i.e., "depression"). Conversely, because points of contact with external reality (e.g., others' reactions and social feedback) intervene continuously, there is also an aspect in which the grandiose world is less likely to be formed in a manner that is completely detached from the shared understanding of those around the person.

What is proposed here is not a general claim about which condition is "more prone to depression". Rather, it is a structural hypothesis: differences in where the grandiose world is constituted (inner self-containment vs. externalization) alter both the characteristics of the grandiose world and the manner in which it connects to "depression", including the kinds of triggers that precipitate its breakdown.

4. Summary

In this chapter, I identified a commonality between schizophrenia and bipolar disorder in that a world-configuration characterized by self-exceptionalism and lacking compassion for both self and other can, while taking on an elevated tone, function as a sustaining ground. I further argued that a key difference lies in where the grandiose world is constituted: in schizophrenia, the grandiose world tends to be self-contained within an inner world and external feedback is less likely to intervene, whereas in bipolar disorder it tends to be externalized and maintained through interactions with external reality, yet those same interactions can also become triggers for its breakdown.

IV. Thought Disorder as the Loss of the "Ground of Thinking"

—A Self-Observational Description of the Impoverishment of Thinking, Difficulties in Language Comprehension, and Alterations in the Operation of Thinking—

1. Positioning of This Chapter (Method)

This chapter describes alterations of thinking in psychotic states on the basis of the author's self-observation and reflections derived from it. The "thought disorder" addressed here is

not intended to reproduce the DSM's description of "disorganized thinking" (e.g., derailment, incoherence, or thought blocking). Rather, this chapter focuses on aspects such as impaired decision-making due to the impoverishment and stagnation of thinking, and describes how these are experienced in the person's inner experience. In addition, it aims to offer a phenomenological organization of how "thinking" itself becomes altered.

2. Diminished Judgment Ability and Thought Disorder: The Loss of the Ground of Thinking

The central hypothesis of this chapter lies in grasping thinking in psychotic states not as an abnormality of thought content, but as a **loss of the ground of thinking**. As a consequence, thinking becomes impoverished and stagnates, and the mode of operating thinking is barely maintained in the form of inner dialogue (self-questioning and self-answering).

When people confront situations they have never experienced before, they do not immediately know how to think. Similarly, when the ground of thinking that one has relied on—namely, the premises of judgment, value criteria, and the framework of meaning-making—loses its validity, it becomes unclear on what basis one should judge, and thinking itself becomes difficult to arise.

When this paper conceptualizes depression as an "existential crisis", this existential crisis can often involve a loss of the ground of thinking. That is, when one's self-world (such as identity and sustaining grounds) collapses, the premises of judgment—namely, "by what criteria one chooses, and how one assigns meaning"—may become destabilized, and thinking may fall into dysfunction.

As a metaphor to explain this point, consider a situation in which economic activity is constituted on the basis of "money". If the concept of money were to lose its validity, many people would not be able to judge immediately by what criteria they should exchange goods or how they should organize their lives. In particular, those whose judgment had relied on a limited set of scales would be more likely to lose their footing.

A second metaphor may be added. Thinking is supported by language. If language were lost and words as inner speech could no longer arise, "thinking" itself could become difficult. Beyond these metaphors, when the ground of thinking loses its validity, thinking may become impoverished and stagnate.

3. What Does It Mean to "Think"?: Automated Thinking and Thinking Under Conditions of

Indecision

Much of the thinking carried out in everyday life is, in fact, immediate and automated. That is, in situations that can be judged instantly on the basis of established value judgments, explicit "deliberation" is often unnecessary. At times, convictions and interpretations that arise automatically for the person concerned—including delusional ones—can organize subsequent thinking and occupy a large part of one's thought activity.

By contrast, in situations where "one cannot make a judgment", thinking often takes the form of self-questioning and self-answering. In this chapter, I provisionally refer to this form as "dialogue-type thinking" (a self-questioning format).

Self-experiential Description

During the period of entrance examinations, I was exposed over a prolonged time to recurrent obsessive symptoms and persecutory delusions, and these thoughts came to occupy most of my mental activity. Although I managed to enter university, my psychological resources were severely depleted. At the beginning of my time at university, it became difficult for thinking to arise, and I fell into a state in which even decision-making about everyday actions was unable to get underway. Profound bodily fatigue was also present, and I could not decide whether to do even basic activities of daily living, such as bathing and toileting. Therefore, situations repeatedly arose in which judgment could barely be reached, even through the dialogue-type thinking (a self-questioning format) described in the previous section.

For example, bathing was often initiated as an inner exchange of reprimand and rebuttal. My inner dialogue at the time generally took the following form (a semi-verbatim reconstruction).
Self A (reprimand): "(to myself) Hey, why aren't you taking a bath"
Self B (rebuttal): "I feel sluggish, and I don't want to"
Self A (reprimand): "That's why your hair is falling out"
Self B (rebuttal): "If I'm exhausted, it can't be helped"
Self A (reprimand): "You're filthy"
Self B (rebuttal): "Shut up"
This dialogue proceeded not in a vocabulary and tone of "compassion", but in a vocabulary and tone grounded in the self–other relationality that predominated at the time—such as blame and contempt.

In this way, thinking leading up to a judgment branched into multiple self-positions (a

reprimanding self and a rebutting self), and it barely advanced through the conflict between them. Such dialogue-type thinking can emerge as a minimal mode of operating thinking that makes decision-making possible under conditions in which the ground of thinking has been weakened.

Similar dialogue-type thinking was also needed when I had to go to the toilet. At the time, I simultaneously experienced (i) a sense that "I cannot think of anything", and (ii) a sense that, even if I were to think, thinking operated only in the form of dialogue-type thinking. I experienced this state as a self-evaluation such as "I've become stupid" (a semi-verbatim expression) or "as if I had returned to being a baby". However, "as if I had returned to being a baby" did not carry a peaceful feeling; during the same period, symptoms such as persecutory delusions, obsessive symptoms, emotional paucity, and diminished motivation co-occurred.

Moreover, the dialogue-type thinking at that time tended to be emotionally colored by mutual blaming, verbal abuse, and ridicule. I was then excessively preoccupied with my thinning hair and was strongly influenced by a persecutory delusion that "others are ridiculing me". This delusional self–other relationality extended into the content of the inner dialogue, down to its vocabulary and tone (ridicule, inferiority, reprimand, contempt), such that the thinking process itself was prone to be organized in a delusional manner (perpetration/victimization).

It should be noted that as long as this dialogue-type thinking is held as "one's own thinking", it is experienced as self-questioning and self-answering. However, in phases in which self-monitoring (sense of agency) declines, similar verbal fragments may become externalized and can be experienced as auditory verbal hallucinations ("voices") or as autochthonous thoughts. This possibility has been discussed as the inner-speech misattribution hypothesis [1,3].

4. The Nature of Thought Disorder: In Language Comprehension (Self-Experiential Vignette)

At the time of onset (during the entrance-examination period), difficulties in language comprehension were prominent. In particular, expressions involving metaphor and emotion became difficult to understand. For example, I could not adequately grasp the emotional implications contained in idiomatic phrases such as "my heart leapt", "one's eyes lit up", "m y heart sank", "tears welled up and spilled", "have a lump in my throat", or "get under my skin". I also found it difficult to infer the writer's intent (e.g., consideration, tact). Moreover,

the longer a sentence became and the more complex the relationships between subject and predicate, the more difficult it was to grasp the context.

By contrast, mathematical tasks were relatively preserved. Mathematics involves less interpretive ambiguity and less emotional implication, and the understanding of meaning is less dependent on linguistic context. At least in my experience, I observed a difference: language tasks requiring the comprehension of emotional expression and the reading of others' intentions were more readily impaired, whereas logical reasoning could remain relatively intact.

This description is an individual self-experiential vignette and is not intended for generalization.

5. Initiating and Expanding Thinking Through Self-Dialogue (A Self-Experiential Strategy)

During the period in which the ground of thinking was weakened and I did not know what, or how, to think, I attempted to construct thinking by using dialogue-type thinking. In doing so, what served as a starting point was the external introduction of a "seed of thought" (i.e., a provisional point at issue). That is, I would receive a provisional topic or perspective from others' accounts or from the discourse around me, and by moving back and forth between agreement and disagreement with it, I expanded my thinking. For example, regarding the nighttime noise of mahjong in dormitory life, I received from a friend a "seed of thought": "Playing mahjong late at night should be stopped". In response, my inner dialogue unfolded as follows.
Self A: "I'm a student, so it's fine to let loose a little."
Self B: "But there's the next day, and it's noisy and bothersome."
Self A: "At this level, I can still sleep."
In this way, starting from a "seed of thought" introduced from outside, I increased the available options for judgment and expanded my thinking by moving back and forth between affirmation and negation.

In this process, thinking expanded to a certain extent, yet limitations were also observed. That is, at this stage, thinking tended to operate only in a format in which "I" was the subject (e.g., "I think this / I want to do this / I do not want to do this"), whereas formats in which another person was the subject (e.g., "He thinks this" or "Everyone thinks this") were difficult to emerge.

In interpersonal situations, when the interlocutor stated, "I'm worried about you", this could imply that the interlocutor was making an appraisal of my future or health—taking the other

(i.e., me) as the subject (e.g., the possibility that I might act foolishly, or that my condition might worsen). At that time, however, because thinking in an other-subject format did not become established for me, it was difficult to understand utterances that presupposed such "other-subject thinking". When I forced myself to interpret them, I was prone to understand them as hypocrisy.

By contrast, a sentence such as "He is speaking ill of me" could be readily converted into a passive sentence with a first-person subject—"I am being spoken ill of by him"—and was therefore graspable. However, "He is showing compassion toward me", even when converted into the passive form "I am being treated with compassion by him", could, under the delusional self–other relationality at the time, be understood only as hypocrisy.

From the perspective of this paper, the recovery of understanding other-subject statements is not achieved through linguistic manipulation alone. Rather, it is likely to involve a weakening of delusional self–other relationality, as well as a transformation toward mutually sustaining self–other relationality.

6. Summary

This chapter described thought disorder as a loss of the ground of judgment (the ground of thinking) and as an accompanying dysfunctional alteration in the operation of thinking. Under conditions in which judgment is difficult, one may be able to think only barely in the form of dialogue-type thinking (self-questioning and self-answering). However, this inner dialogue is often colored by verbal abuse and contempt, and is prone to operate under the influence of delusional self–other relationality. It has also been widely discussed that similar linguistic experiences may become externalized when self- monitoring (sense of agency) declines, and may be experienced as auditory verbal hallucinations ("voices") or as autochthonous thoughts [1,3].

V. Integrating Psychotic States from a Psychoanalytic Perspective

1. Psychoanalysis and Neurosis

Freud recognized that the mind consists not only of consciousness but also of the unconscious, and he pointed out that unconscious dynamics can influence conscious thought and behavior. Although the unconscious is a concept that includes "psychic contents of which one is not aware", clinically it was emphasized that such contents may remain unmentalized and unrecognized due to repression, while nonetheless continuing to exert

psychological effects through symptom formation. This concept subsequently exerted a broad influence on later psychoanalysis as well as on a wide range of psychological theories.

Freud took the examination of parapraxes (so-called “Freudian slips”) as a point of departure and argued that slips of the tongue and deviations in action that run counter to one’s conscious intention need not be understood as accidental failures, but can be grasped as expressions of unconscious intention. In one of his works, Freud cites a case in which a parliamentary chair, at the opening of a session, misspoke and said, “Having confirmed the attendance of the members, I hereby declare the session closed”. Freud suggested that, in that situation, an unconscious wish—namely, “If we open the meeting, nothing good will come of it; if possible, I would like to close it at once”—may have been operative and articulated in language contrary to the speaker’s conscious intention [4, vol. 1, pp. 50–53].

Freud further conceptualized neurotic symptoms as products in which certain psychic wishes are repressed and kept unconscious (repression), and the repressed contents are expressed in a transformed form. With respect to treatment, Freud argued that by “replacing/translating what is unconscious into what is conscious”, repressed contents can become conscious, and neurotic symptoms may thereby be alleviated or disappear [4, vol. 2, pp. 325–326]. In Freud’s clinical practice at the time, he often discussed the involvement of moral norms—including sexual morality—as repressing forces; this point should be understood in light of its historical and social background.

As a concrete illustration consistent with Freud’s argument, one may refer to the case vignette described in Lecture 16 of *Introductory Lectures on Psycho-Analysis* [4, vol. 2, pp. 25–32].

Freud’s Case Vignette

At the request of a young officer who had returned to his hometown on a short leave, Freud examined the officer’s mother-in-law (a middle-aged woman). Triggered by an anonymous letter, she became gripped by the conviction that her husband was involved with a younger woman, and jealous delusions came to the foreground. Fragmentary clinical observations suggested that, although the immediate precipitant of the symptoms was an external event (the letter), internal conditions had already been prepared prior to it.

That is, while the delusion took the form of a narratively plausible story—“the husband’s infidelity”—at a deeper level there may have been a strong romantic attachment on her part toward a younger man (in particular, the officer, who was her son-in-law), which, because it was not morally permissible, could not be consciously acknowledged and therefore remained repressed. Because the repressed desire does not directly come into consciousness, it may be

displaced into the form “my husband is involved with a younger woman” and experienced projectively as the husband’s infidelity. As a result, the delusion can be painful for the person while, at the same time, functioning unconsciously as a mitigation of guilt and a form of self-justification.

Freud depicts this configuration as follows: although the projected image derives from the original image, the original image itself does not become conscious and is retained in the unconscious.

2. A Self-Experiential Vignette: An Attempt at Psychoanalytic Self-Understanding and Its Limitations

After entering university, I exhibited obsessive symptoms, persecutory conviction, stagnation of thinking, profound bodily fatigue, diminished motivation, emotional paucity, somatization, and so on. In that context, I attempted to develop a psychoanalytic understanding of myself through independent reading in psychoanalysis and related psychological books, including Introductory Lectures on Psycho-Analysis.

In the course of this process, I realized that, under an upbringing in which academic performance was strongly demanded, I had internalized norms such as “I must get good grades” and “I must be a good child” in order to avoid being reprimanded for poor performance, and had lived while being excessively preoccupied with the reactions of others (my parents). For me, these norms had long been self-evident and unquestioned, and they operated as a criterion for action selection without being consciously examined; in that sense, they functioned as an unconscious premises. Moreover, this was accompanied by a tendency to prioritize “grades” even at the cost of sacrificing other interests and desires (grade-firstism). During the entrance-examination period, these premises were further reinforced: an obsessive thought repeatedly arose—“At this rate, you will fail the exams”—and, in response, a compulsive behavior took shape in the form of excessive checking of study plans, eventually becoming fixed as an obsessive symptom.

At that time, I understood these obsessive symptoms in terms of the following configuration: “educational norms intensified the repression of psychic contents, and while the repression did not become conscious, its transformed products were expressed as symptoms”. I further attributed the background of this repression to my parents’ upbringing and repeatedly expressed anger in the form “this happened because of my parents”. However, even after a certain period of time, there was little symptomatic relief, and I was confronted with the fact that the psychoanalytic map—“if the repressed unconscious is made conscious, neurosis will

be cured"—had not, at least with respect to my own obsessive symptoms, yielded a therapeutic outcome.

As a result of this experience, I was compelled to examine where the limits of psychoanalytic treatment might lie. More specifically, three questions became central.

First was a diagnostic question: whether the obsessive symptom that I regarded as my principal symptom should be understood as obsessive–compulsive disorder, conceived as a neurosis, or whether it should be situated within the schizophrenia spectrum (given that psychoanalysis has primarily addressed neuroses, and its applicability to schizophrenia-spectrum conditions is often considered limited).

Second was a question concerning the range of effectiveness: even if this symptom was to be included within the same concept of neurosis, psychoanalytic intervention might be less likely to bring about sufficient improvement when symptom severity is high.

Third was a question concerning analytic precision: whether making the repressed conscious had still been insufficient, such that there might still be "something" that had not yet come into consciousness.

Through subsequent self-observation, what came to matter most for me among the three questions above was in particular the third: whether there might still remain "something" that had not yet been made conscious. The conclusion I ultimately reached was that a temporal understanding—repositioning the event as "fully in the past" (past-ification)—had not been established. In one of his works, Jung suggests that the unconscious lacks a concept of time: for it, there is no past or future—only an "eternal present" [7, p. 323]. In my experience, even when repressed contents were made conscious, as long as the event was not separated from the "here-and-now" and continued to operate within the unconscious as if it were still present , the lifting of repression was not completed and could contribute to the persistence of symptoms. For me, what had not yet been brought into consciousness was this enduring quality within the unconscious—its "non-past-ification"—and I later came to understand that translating it onto the conscious temporal axis as "already past" (i.e., establishing past-ification) was a decisive element for symptom change.

What, then, does it mean to "establish past-ification" in the unconscious that lacks a concept of time? In my understanding, it consists in an event comes to be experienced, even at the level of affect, as "fully in the past". This process is experienced in the unconscious as a kind of transformation in self–other relationality. For convenience, in this paper I refer to this unconscious-level transformation as "forgiveness" (corresponding, at the level of

consciousness, to “past-ification”).

“Forgiveness” refers to an unconscious-level transformation in self–other relationality, and it is not a matter of consciously commanding oneself, “I will force myself to forgive”. Rather, attempts to forcefully achieve “forgiveness” can function as a moral pressure imposed on the unconscious—that is, as another form of repression—and may contribute to symptom formation. In my experience, as my autonomy progressed and I built new interpersonal relationships, my dependence on my parents diminished; as my capacity to understand my parents’ state of mind also increased, “past-ification/forgiveness” became easier to establish in a natural, unforced manner. Conversely, in phases in which forgiveness does not become established, it is important not to negate the feeling of “I cannot forgive” itself. At the same time, I came to understand that the repetition of resentment can fix the relationality in place and may work in the opposite direction to past-ification (i.e., forgiveness).

Moreover, in this paper, I emphasize as a feature of the unconscious the aspect that the distinction between self and other cannot be made—namely, self–other undifferentiation. Jung likewise suggests that, at the unconscious level, the attribution of events (whether something happened to “you” or to “me”) is not differentiated [7, p. 100]. From this perspective, my aggressiveness (blame), even if directed toward my parents, cannot be clearly separated at the unconscious level from an attack on “me” and may return as self-attack. As a result, it may also be expressed as symptoms that torment the self, such as persecutory conviction, obsessive symptoms, stagnation of thinking, profound bodily fatigue, diminished motivation, emotional paucity, and somatization.

On the other hand, “forgiveness/past-ification” as used here does not require direct reconciliation with the relevant other (one’s parents) as a necessary condition. In my experience, even when the relationship with one’s parents is not sufficiently repaired, as mutually sustaining relationality (e.g., compassion, mutual respect, and gratitude) is formed and sustained in other interpersonal relationships, self-compassion at the unconscious level becomes easier to establish and may contribute to symptomatic relief. As a consequence, this may also incidentally help “forgiveness/past-ification” toward the other (one’s parents) to develop gradually.

3. The Relationship Between Depression (Existential Crisis) and Neurosis: From a Psychoanalytic Perspective

As discussed in the previous chapter, this paper conceptualized depression as an “existential crisis.” However, this “existential crisis” is described primarily at the level of consciousness,

and the same situation may take on a different aspect when viewed from the level of the unconscious.

For example, when viewed from the level of consciousness, a norm such as “I must be a good child” may function as meaning for one’s existence (a sustaining ground). From the level of the unconscious, by contrast, the same norm may operate as a force that represses unconscious wishes and affects, thereby potentially contributing to the formation of neurotic symptoms.

Here, loosening repression may, from the level of the unconscious, work in the direction of weakening the underlying conditions for symptom formation. From the level of consciousness, however, it may be experienced as a destabilization of “being a good child,” which functions as meaning for one’s existence (a sustaining ground). That is, the lifting of repression can, at the level of consciousness, emerge as a loss of the sustaining ground and may thereby connect to “depression” as an existential crisis.

Accordingly, neurosis can be understood as a condition in which symptoms are formed through repression imposed on psychic contents at the unconscious level, while from the level of consciousness, it can also be understood as a stance of clinging to norms in order to avoid the collapse of one’s sustaining ground (i.e., a depressive shift). In other words, in obsessive–compulsive disorder (so-called obsessive neurosis), weakening obsessive symptoms may simultaneously connect to an existential crisis and can mean the emergence of “depression.” In particular, it is also plausible that obsessive symptoms are maintained in order to avoid anxious distress—that is, an existential crisis experienced in an imminent form (distress centered on acute anxiety and fear). In this paper, depression and neurosis are positioned as interconnected phenomena in which the same psychoanalytic dynamics are described from different levels—consciousness and the unconscious.

4. The Unconscious and Self–Other Relationality

From a psychoanalytic perspective, delusion can be understood as arising from unconscious dynamics (or, at times, from the preconscious level) and can be experienced as thought content that repeatedly emerges beyond the person’s conscious control. This paper redefined delusion as a mode of thinking and a mode of relating that arises from a self–other relationality that harms both the self and others; I consider that this self–other relationality exists in the unconscious domain as a repetitive pattern (a ground). On this basis, bringing into consciousness (and articulating in language) the self–other relationality underlying delusion corresponds, in the psychoanalytic map, to the work of “replacing/translating what

is unconscious into what is conscious," and may weaken the binding force of delusional self–other relationality, thereby promoting its transformation.

For example, a person who has engaged in harassment may repeat the behavior without necessarily being sufficiently aware of the aggressiveness within the self. However, when the person recognizes the behavior as an expression of their own internal aggressiveness and brings it into consciousness, that aggressiveness may be relatively weakened and the self–other relationality may be transformed. Here, "recognizing one's own aggressiveness" does not remain at the level of merely understanding in words that "I hurt the other"; it also includes the other's pain becoming a felt sense for the person—that is, it entails a sensory and affective understanding (an understanding of what is unconscious).

Moreover, this paper also defined a mutually sustaining self–other relationality that it calls "love," and I consider that this self–other relationality likewise exists in the unconscious domain as a repetitive pattern (a ground). That is, the expression of love-based self–other relationality is carried out not so much as a matter of the person's conscious intention as rather as a mode of thinking and a mode of relating that arises automatically and habitually. For this reason, from an external standpoint it may be observed as having features such as not seeking reciprocity and showing little sense of self-sacrifice or self-display.

On the other hand, if love that resides in the unconscious domain becomes consciously formulated in terms such as "I am loving" or "I am kind," love may readily become goal-directed and turn into a matter of self-checking; as a result, the unconsciousness and automaticity (spontaneity) of love may be undermined. Excessive praise or pointed remarks from others may likewise make the person self-conscious about their love.

From the standpoint of this paper, while making delusional self–other relationality conscious can weaken its binding force and repetitiveness, the aim for love-based self–other relationality is consolidation in a form that is not consciously formulated—that is, its establishment at the unconscious level. Accordingly, expressions such as kindness and compassion, which are manifestations of love, are best sustained not as "conscious virtues" but rather as expressions of a love-based self–other relationality that operates unconsciously.

As a supplementary note, "love"—that is, a mutually sustaining self–other relationality—is commonly manifested as kindness, compassion, gratitude, forgiveness, and respect. From the standpoint of this paper, however, these are nothing more than concrete expressions that arise in response to situational demands from a repetitive pattern of self–other relationality in the unconscious (a ground). Depending on the situation, in confronting another's delusion, love may also be expressed as refusal or anger.

On the other hand, attempting to forcefully think and enact these manifestations as something one "ought" to do causes them to function as morality or norms. From a psychoanalytic perspective, morality and norms can in some cases operate as repression imposed on the unconscious and, as a result, may contribute to symptom formation.

Next, I show that even when the same act takes an identical outward form, its meaning can nonetheless differ depending on the self–other relationality (unconscious motive) that is operating behind it.

For example, imagine a situation in which a woman walking ahead drops her handkerchief, and one picks it up and hands it back to her. Even if the outward expression of the act is the same, its meaning at the unconscious level is not identical when the act arises from genuine consideration (compassion) versus when it arises from ulterior motives that include seeking favor or exerting control over the relationship.

Furthermore, the person may in some cases regard the act as "kindness" without being sufficiently aware of their own motives (ulterior motives). In such cases, when the other person responds with distancing or refusal, the person may feel dissatisfaction or anger. An act initially presented as kindness may, in response to the other's refusal, be transformed into a sense of victimization or aggression—"After all I have done for you." This pattern is also often observed in sexual harassment. By contrast, when consideration (compassion) at the unconscious level guides the act, negative affects are less likely to arise in response to similar reactions from the other. Accordingly, when negative affects (e.g., dissatisfaction or anger) arise after the other has distanced themselves, this can become an occasion for self-analysis (self-checking) of one's unconscious motives and self–other relationality.

On this basis, in a person for whom delusional self–other relationality is dominant at the unconscious level, the modes of thinking and the modes of relating that arise there may, even if the person intends at the level of consciousness to express "love", be distorted into forms such as a sense of self-sacrifice or an expectation of reciprocity; that is, these forms themselves constitute a reproduction of delusional thinking. In other words, even if the outward manifestation appears to be "kindness" or "consideration", as long as the underlying self–other relationality remains delusional, the act does not constitute a mode of thinking and a mode of relating grounded in love-based self–other relationality.

From the consciousness of a person in whom delusional self–other relationality is dominant, this configuration can readily be taken to mean: "Does everything I think ultimately become delusional?", "Do I have no love?", or "Must I not think anything at all?". However, this understanding arises when the person recognizes that delusional self–other relationality is

operating within their own unconscious. By contrast, when the person does not recognize that delusional self–other relationality exists within the self (within the unconscious), the problem is more readily grasped as residing not within the self but in surrounding people or the environment, and may be expressed as persecutory delusion or the development of hostility.

5. Practice After Becoming Aware of Delusional Self–Other Relationality (Cognitive-Behavioral Therapy)

When a person who has recognized that delusional self–other relationality is operating within the self encounters the concept of "love," this recognition is often accompanied by the understanding that "I do not have love (i.e., a mutually sustaining self–other relationality)." This understanding can involve a sense of impasse—something that feels beyond one's immediate control. Yet, in the course through which delusional self–other relationality is transformed, it can become a starting point for grasping the very direction of treatment. That is, from the point at which one becomes aware that delusional self–other relationality is dominant and, for that reason, accepts the fact of "lacking love," practice toward a love-based self–other relationality can begin.

At this point, what arises for the person is not a resolve, but questions accompanied by a sense of bewildered helplessness: "How can I become someone who is able to love others?" and "What can a person who does not know how to love possibly do?"

Although "love" is often explained as "unconditional love", a definition such as "devoting oneself to the other without seeking anything in return" is too abstract and idealized for the person concerned to grasp. In this paper, I therefore propose the following, more readily understandable indicator: "a truly kind person is not consciously aware that they are being kind". Precisely because such a person is unaware of their own kindness, they neither seek reciprocity nor develop a sense of self-sacrifice or self-display, such as "I am doing this for the other".

Just as strong delusion tends to lack insight, strong love likewise tends not to give rise to the awareness that "I am able to practice love", but instead operates in the unconscious domain. In this respect, the two can be understood as having an isomorphic structure. Accordingly, what the person should aim for is not the conscious performance of love, but rather a direction in which love is practiced naturally, in such a way that it does not rise into consciousness.

However, it is difficult for the person concerned to practice love immediately and unconsciously. Therefore, the first possible practice at this point is to refrain, as much as possible, from repeating delusion at the opposite pole of love—that is, thoughts that arise from delusional self–other relationality. For example, self-deprecation and self-blame, such as "After all, I am incapable of love" or "I am to blame for being unable to love", operate as thoughts arising from delusional self–other relationality and may fix that relationality in place. Conversely, if the person genuinely wishes to "become someone who is able to love others", that very orientation itself creates distance from delusional self–other relationality and can become an occasion for reducing the repetition of delusion.

Nevertheless, for a person who has relied on delusional self–other relationality as the primary ground of thinking, "not engaging in delusional thoughts" often involves a sense of being unable to think at all. As discussed in another chapter of this paper, when the ground of thinking—the premises of judgment, criteria of value, and framework for meaning-making—ceases to function, thinking itself becomes less likely to arise.

Accordingly, the temporary blankness that arises immediately after the former ground, namely delusional self–other relationality, has been shaken can be understood not so much as a setback, but rather as an initial sign of transformation. It is first necessary to acknowledge and accept this blankness and then to develop, as the person's own thought, what they can do for the other and give it concrete form.

For the person concerned, bringing into being the modes of thinking and the modes of relating that belong to love-based self–other relationality, which is recognized as "nonexistent", is close to the feeling of creating one from zero. The act chosen at this point may be small, but it is important that it be feasible within a range that does not involve a sense of self-sacrifice. This is because, when a sense of self-sacrifice arises, the act becomes less likely to operate as an expression of love; rather, the act itself is more readily reabsorbed into delusion, such as an expectation of reciprocity, a sense of victimization, or aggressiveness. Therefore, when a sense of self-sacrifice appears, it is necessary to stop for the time being and readjust the act into a form that, for the person concerned, does not involve a sense of self-sacrifice.

When the person concerned finds it difficult to find clues solely within the self, it may be helpful to observe everyday interpersonal situations from the perspective of how others express love in a natural manner among the people around them.

The unconscious love of others tends to be expressed in inconspicuous and subtle ways. For this reason, for a person dominated by delusional self–other relationality, love itself is often difficult to perceive in the first place. Accordingly, for the person concerned, becoming aware of the modes of thinking and the modes of relating of others' love-based self–other relationality is less a matter of learning existing norms or correct answers than an experience akin to discovering one from zero.

Once a concrete image of love has been discovered, the person can use that manner of expressing love as a clue. Then, with the aim of approaching a similar felt sense, it may be helpful to practice it within a range that, for the person concerned, does not involve a sense of self-sacrifice.

These practices, however, should not be carried out with "cure" as their aim—that is, as an expected return. In other words, if the expectation of "getting better" or achieving "results" drives the act, the act becomes goal-directed as an object of evaluation and exchange, making it difficult for it to become established as an expression of love-based self–other relationality. Similarly, evaluating oneself as "having been able to be kind" and feeling pleased about it can also become an occasion for self-checking or self-display, and may likewise hinder the establishment of love-based self–other relationality.

In addition, pushing these practices forward too hastily may, in some persons, lead to elevation or grandiosity. Moreover, the idea that "I must love others" may turn into an obsessive thought and shift toward repressing the unconscious. Taking these points into account, it is important to continue the practice without haste, while wishing to "become someone who is able to love others", without turning the result—such as cure or achievement—into an aim, and within a range in which a sense of self-sacrifice does not arise.

When the above is organized in light of the major concepts of CBT, the correspondence can be summarized as follows (Table 1).

Operational Concepts in CBT	Correspondence in the Model Proposed in This Paper
Self-Monitoring	Becoming aware that one's own thoughts are operating from delusional self–other relationality. At the same time, recognizing the absence of love-based self–other relationality.

Distancing CognitiveDistancing/Decentering	The wish to “become someone who is able to love” creates distance from delusional self–other relationality.
Behavioral Experiment Small Behavioral Experiment	Discovering or creating for oneself what one can do. Continuing the practice without haste, without turning the result—such as cure or achievement—into an aim, and within a range in which a sense of self-sacrifice does not arise.

Table 1. Correspondence Between the Operational Concepts of CBT and the Model Proposed in This Paper

The therapeutic process is a repetition in which delusions are transformed one by one, and the love that has begun to take shape is returned to unconscious operation; this process is then repeated with another delusion. Accordingly, in the process through which symptoms are alleviated, love is not recognized as a conscious achievement, but rather becomes unconscious—that is, it comes to be taken for granted. For example, as a transformation at the unconscious level, this is closer to the sense that “an environment is provided in which gratitude arises spontaneously” than to the sense that “one becomes able to practice gratitude”.

By contrast, attempts to measure one’s “degree of achievement in love” through self-checking or comparison with others may undermine the unconsciousness and spontaneity of love. Moreover, becoming self-satisfied with the idea that “I have love”, or comparing the amount of love in oneself and others and making judgments of superiority or inferiority, can be understood as behaviors that reactivate delusional self–other relationality. Therefore, in every phase, the basic stance is to become aware of one’s own delusional self–other relationality and to maintain the wish to “become someone who is able to love others”.

Finally, from the standpoint of this paper, I will state the endpoint of the therapeutic process in a speculative manner. What follows is not a conclusion based on empirical evidence, but rather a hypothetical inference by the author. In a state in which delusional self–other relationality has sufficiently weakened and delusions no longer come to the foreground, the basic tone of self–other relationality may shift toward “love” (mutually sustaining self–other relationality). However, if this “love” itself becomes established as unconscious operation, the person’s awareness of the very concept of “love” may also diminish. Paradoxically, it may be precisely because there is a phase of delusion that “love” becomes conscious as a point of contrast.

Furthermore, at this stage, delusional thinking and the thinking used to orient oneself toward “love” may recede from the foreground, while intuition and sensibility may come to the foreground. Unlike the blankness of thinking observed when the ground of thinking ceases to function, the capacity for thinking itself is not impaired; rather, thinking may come to be used more freely. The thinking that arises at that time may perhaps take forms such as prayer, play, or creative activity, including art.

6. Summary

In this chapter, while referring to Freud’s framework of the unconscious, repression, and symptom formation, I positioned the concept of delusion redefined in this paper—namely, “a mode of thinking and a mode of relating that arises from self–other relationality that harms both the self and others”—as a dynamic at the unconscious level.

In the self-experiential case, I presented the hypothesis that there are cases in which making repressed contents conscious alone may not readily lead to symptomatic improvement, and that what becomes important in such cases is that the event is “past-ified” even at the affective level, thereby bringing into consciousness the temporal persistence of the event in the unconscious.

In addition, on the basis of the perspective at the level of consciousness that understands depression as an “existential crisis”, I described its relationship to repression at the unconscious level and discussed the relationship between depression and neurosis.

Finally, I showed how the transformation from delusional self–other relationality in the unconscious domain to love-based self–other relationality may be experienced from the side of consciousness, and presented the direction of treatment. As practical procedures, drawing on the concepts of CBT, I outlined guideposts corresponding to self-monitoring, distancing, and small behavioral experiments.

Through the above discussion, this chapter presented a framework for integratively understanding, from the perspectives of consciousness and the unconscious, the psychopathological redefinitions proposed throughout this paper.

Conclusion

When patients confront a psychotic state, individual symptoms are often experienced not as appearing in isolation, but rather as an interrelated “cluster of symptoms”. In such a

situation, the urgent issue for the person concerned is to grasp how their own condition, including its diagnostic name, is placed amid the confusion, and to discern the direction of treatment.

However, on the basis of this “cluster of symptoms”, it is not easy for the person concerned to recognize, in particular, a condition within the schizophrenia spectrum. To determine whether or not one has schizophrenia, it is necessary to discern whether one’s own thoughts correspond to delusion. Yet, as long as delusion is defined in current diagnostic systems as a “deviation from reality”, the person concerned cannot evaluate their own thoughts according to the same criterion. That is, under conventional operational concepts, self-diagnosis of schizophrenia, including self-judgment of delusion, is difficult in principle.

In light of this difficulty, this paper redefined delusion as a mode of thinking and a mode of relating that is expressed from self–other relationality that harms both the self and others. Furthermore, by drawing on the psychoanalytic concepts of consciousness and the unconscious, I repositioned delusion as a dynamic at the unconscious level, thereby strengthening the theoretical perspective for understanding delusion. In addition, as a direction of treatment, I introduced the concept of “love” (mutually sustaining self–other relationality) and presented a theoretical map in which delusional self–other relationality is transformed and the love that has begun to take shape becomes established at the unconscious level—that is, comes to operate unconsciously. Here, I emphasized the absence of temporality and self–other undifferentiation as characteristics of the unconscious.

This paper also redefined depression as an existential crisis, that is, as the loss of a sustaining ground, and explained the connection between delusion and “depression”. That is, while delusion may support the subject as a sustaining ground, when that ground becomes shaken, “depression” as an existential crisis may arise. Furthermore, from a psychoanalytic perspective, I showed the possibility that neurotic symptoms may be formed by psychic operations that attempt to avoid “depression” (existential crisis), and repositioned depression and neurosis as descriptions, at the levels of consciousness and the unconscious, of the same dynamics.

In addition, this paper organized the relationship between schizophrenia and bipolar disorder, as well as the position of thought disorder, under the above redefinitions. That is, I presented as hypotheses that schizophrenia and bipolar disorder may have continuous and structurally similar features, and that the loss of the ground from which thinking arises—the premises of judgment, criteria of value, and framework for meaning-making—may be experienced as thought disorder.

Finally, I will discuss the limitations of this paper and future issues. In clinical settings, patients' narratives are not free from the influence of the norms and evaluative axes of contemporary society, and there is a possibility that the details of the psyche may not be sufficiently articulated. Moreover, insofar as the discussion includes the unconscious level, there remain domains that even the person concerned cannot grasp, and there may also be cases in which bringing unconscious contents into consciousness is not necessarily best for the person concerned.

Therefore, the theory presented in this paper relies heavily on the self-experiential case and the hypotheses derived from it, and its validity in other cases requires future examination. Nevertheless, in light of the limitation that the operational concepts of current diagnostic systems are difficult to connect with the self-understanding of the person concerned, it would be fortunate if the redefinitions proposed in this paper could serve as an occasion for promoting the understanding of psychopathology and contribute to the person's self-understanding and therapeutic orientation.

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