The Contributions of Psychoanalysis To Psychiatry[1]

(Ettore Jogan)

Introduction

Based on my personal experience as a psychiatrist and psychoanalyst, I have established that my psychoanalytical approach to severe pathologies (strong personality disorders and psychosis) has developed slowly and gradually and my personal experience of the contributions of psychoanalysis to psychiatry has therefore taken shape and strengthened only in the last 15 or 20 years. I believe that experience of this kind is typical for psychiatrists and psychoanalysts of my generation, because we have all studied and developed professionally during a particular time period. In Italy in the 60's and 70's, there was great division and conflict between biologically orientated psychiatry (which was based on a medical model and mainly operated with psycho-pharmacological drugs) and psycho-genetically oriented psychoanalysis which supported only psychological intervention. Within the contrast between biologically rooted psychiatry and psychologically oriented psychoanalysis, we also had the development of the very divided dualistic concept of psychopathology. Part of the realm of psychiatry was dealing with difficult pathologies (especially psychosis), which were considered exclusively of biological or endogenous origin (believed to be generally organic, even if this had never been proven), part of the area of psychological approaches (where the psychoanalysis was taking the lead) were psychical pathologies, for example neuroses, which were considered of mainly psychogenetic origins.

Circumstances started changing after the 70's and the dialogue between biological psychiatry and psychoanalysis gradually opened up: many psychiatrists in the larger centres of Italy studied psychoanalysis or at least conducted their personal psychoanalysis. A more concrete contribution of psychoanalysis to psychiatry started taking shape when some

psychoanalysts started getting in touch with psychiatric institutions, either for counselling or as supervisors. Even though the dualistic vision between the physical (brain) and psychological (mind) is quite present in Italian psychiatric culture, a marked contrast or distrust of psychoanalysis is no longer as evident today as it was in the past. It is known that currently, a general negligence for the psychological aspects of psychic events is spreading because of the present predominance of biological- psychopharmacological psychiatry.

Biologically oriented psychiatry has always been against psychoanalysis because it was labelled non scientific and therefore not correspondent to the empirical and experimental criteria of testing which are legalised in medicine.

For its part, psychoanalysis has also had some reconsideration and resistance to approach and make an effort to heal severe pathologies especially in the area of schizophrenic psychoses. We were aware of certain psychoanalysts in different countries (as for example the USA, England, France and Italy) who were exclusively dedicated to this very demanding task, that is to say the healing and studying the problems of psychosis, and we regarded them as brave and pioneering researchers rather than an expression of great interest for psychoses on the part of the international psychoanalytical establishment. In one of my previous publications (Jogan 2005) on this subject, I exposed three factors which have, in my opinion, influenced a psychoanalytical "resistance" to psychoses. The first factor is linked to the problem of theoretical approach to psychoses, the second factor is linked to the problem of a technical approach to psychoses, the third factor is linked to the problem of institutional policies in the education of psychoanalysts which leads to the building of professional psychoanalytical identity.

Before we look into these different points of view, which were concerned in psychoanalytical psychotherapeutic approach to psychoses and gave a significant contribution to psychiatry, I would like to expand on some general psychoanalytical factors which have given and are still giving a more general and approximate contribution to the psychiatry.

[1] This paper was presented in 2006 in Trieste at the meeting with Croatian and Serbian psychoanalysts

General or non specific contribution of psychoanalysis to psychiatry

As a starting point for the enlightening of this topic, I will mention the controversy which I came across in Int. J. Psychoanal. from 2003 (1st part) between the English psychiatrist and psychoanalyst Richard Lucas and the American psychoanalysts Martin S. Willik (who is only mentioned in the article) and Robert Michels (who directly intervenes in the debate). The content of the debate is centred on the relation between psychoanalysis and schizophrenia (I would rather discuss freely the relation between psychoanalysis and psychiatry). The American authors are extremely critical and have negative tendencies towards psychoanalysis in this context, saying that up to now, psychoanalysis, with its psychoanalytical starting points at schizophrenia, hasn't significantly contributed therapeutically to healing this severe psychiatric pathology. They support this thesis in their own fashion which I can not enlarge upon within the confines of this text. The two American authors state that psychoanalysis, with its theories, its methods and with its own cultural approach, can at best be useful to psychoanalytical, psychological, social and pedagogical operators or to patient's relatives who are dealing and coping with these difficult patients. Psychoanalysis should offer to these people a general look at the internal psychic state of the patient, should give a sense and an explanation to pathological cases, which should have a helpful influence on people who are in touch with these difficult patients.

The English author Richard Lucas has a different opinion and also openly supports a specific contribution of psychoanalysis, when treating psychotics, and therefore the value of effectiveness of psychoanalytical psychotherapeutic approach to psychoses. I am personally more inclined to support the position of R. Lucas which I will discuss later on in my lecture, however, I also think that the American authors' argument is a very useful one. These two psychoanalysts emphasise the non specific contribution of psychoanalysis to psychiatry which I believe to be a very important reference point. I think that on a more general cultural level,

psychoanalysis acts an important part also in this non specific contribution to psychiatry. Even if we have not yet been able to organise more specific psychotherapeutic interventions for seriously ill psychiatric patients, it is very important to create a psychoanalytical cultural environment around psychiatric structures and work. What does this mean? In my opinion Glenn Gabbard (1994) has the clearest view when he talks about the concept of "psychodynamic psychiatry". This psychoanalytical approach to various psychiatric pathologies, identifies with a certain way of thinking, with a specific way of observing and looking at the psychiatric problem even before we think about some theoretical and technical specific approaches. The therapeutic approaches in this context can be completely different from the psychotherapeutic one (e.g.: pharmacological intervention, social rehabilitative intervention, etc.), but they are part of a wider frame of a psychoanalytic consideration. Gabbard points out that the concept of "psychodynamic psychiatry" does not identify with psychoanalytical psychotherapy. For this general psychoanalytical approach and contribution, it is not necessary and real for all psychiatric professionals to have such explicit experience or preparation. In a psychiatric team we usually find people with a different level of psychoanalytic education; the most important thing is that these people are motivated to do their jobs, that they don't harbour hostilities and prejudice against psychoanalytic ideas, that they genuinely show interest in psychological knowledge and that these individuals have an interest in personal and professional growth.

What does, according to Gabbard, this "specific way of thinking" consist in? Above all it differs from the traditional, medical psychiatric approach, which objectifies the patient as much as possible and treats him as a sick person, as the carrier of pathological phenomena and symptoms, makes him passive in the diagnostic process and even more in the psychopharmacologic therapeutic program. This approach entraps the patient into previously built in mental schemes and categories which leave him very little active collaboration and participation in his therapeutic process. Psychoanalytical way of thinking and psychoanalytical approach is trying to understand the patient as a whole person above all and not only as a sick person and therefore as the pathology carrier. Each person has his or her own particular individual natural characteristics, his or her own particular personal life story and experience is

unique and original in comparison to other people. With this approach we are not focusing on the symptoms and evident pathologic phenomena but we put emphasis on personal, individual experience. From these principles we can connect to one of the most essential concepts of psychoanalysis, that is the notion of the unconscious, which is constantly reminding us of the complexity of the human psyche,which is divided into layers, and does therefore not allow us to deal with the patient's external appearance or behaviour when meeting him, but we must always ask ourselves what is hiding behind the symptoms? What is the deeper meaning of what the patient is going through on a conscious and more visible level?

If, when dealing with a seriously ill psychiatric patient, we are more psychoanalytically equipped, we will also bring in some psychoanalytical principles, that is the concept of psychic determinism, that the past is very important to build the present, that experiences in early childhood are essential for later formation of personality. We will dedicate special attention to the concept of transference and counter-transference. Repetition of certain forms of object relationships in the present which we had formed and internalised during childhood will be demonstrated by the patient right from the beginning of his treatment and will be present throughout the course of therapy, even if this is not specifically psychotherapeutic. By examining our own reactions towards the patient (feelings of countertransference), we will discover further information about his internal world. The concept of defence mechanism and resistance is also very important in psychoanalysis. Every person provides for his own internal balance with his defence mechanisms, which are, even if pathological and unsatisfactory, functional in its own way, because the patient has not managed to create a better condition under the given circumstances. The majority of symptoms have this function and in a psychoanalytical approach it is therefore not appropriate to directly attack these defence mechanisms, try to eliminate them, often by making the patient completely passive (e.g. with a strong pharmacological therapy or even by force).

When we are dealing with a seriously ill patient, we will be, with a psychoanalytical way of thinking, more respectful towards the patient as a person, towards his pathology and also towards the resistance that he will show towards medical treatment (something very common in psychotic patients). At the initial so-called diagnostic interviews, we will already try to be

more understanding and also more empathetic towards his pathologic conviction, we will give him more freedom and space to allow him to express himself freely (with the use of free association), we will give him a more active part and a more significant personal participation in the process of healing. In this more relaxed manner, we will try to understand from the patient which are his healthier and more mature parts, which ones are more pathological and regressive, what are his defence mechanisms, which are his internalised object relations that he will show in the relationship with us and we will try to introduce him into a more active collaboration in the process of healing. This approach totally differs from the traditional psychiatric one, where, in the diagnostic procedure we already try to direct the patient and to define him at best with our nosographic schemes, later to treat him in a "passive" pharmacological way with him passively awaiting improvement of the clinical state, where the therapeutic mandate is totally handed over to pharmacological drugs.

In Gabbard's opinion, in a psychoanalytic approach to the severe ill patients, we should pay attention to the following elements:

1) The level of ego structure : the capacity of the ego, strong or week; which defence mechanisms he establishes, what is his relationship with reality
2) Object relations: what level is the patient developing his object relations on (on a more mature one, or more primitive?)
3) Structuring of the self: is the self strong and cohesive enough? Or is it fragile and at risk of fragmentation and dissociation?

We must point out that psychoanalysis has its own way of looking at psychiatric pathology in general and arranges pathologies according to a criterion of development. In this sense less critical pathologies, such as neuroses, belong to a higher and more mature level of psychic development, more serious pathologies, such as psychoses and severe personality disturbances, to a lower and more primitive level of psychic functioning. This theoretical model represents a very original concept in comparison with the traditional medical concept. Two concepts are very important in this notion: the notions of regression and fixation.

In this general or non specific contribution of psychoanalysis to psychiatry I would like to point out that this contribution does not only add to psychiatry a general cultural frame, but it also gives some ethical values which are not an intelligible matter in traditional psychiatry. At this point I would like to cite two clinical cases which illustrate the difference between the approach to "psychodynamic psychiatry" and traditional psychiatric approach.

The first case is detailed by Lukas in the above-mentioned article in the Int. J. Psychoanal.: a patient comes into the emergency ward in an acute psychotic state. He's raving deliriously and is screaming that he is God's eldest brother. A psychiatrist with a psychoanalytic preparation is trying to find a way to get in touch with him and he replies that he understands how hard it must be for him having had all the popularity taken by his brother, who then places him in shadows with his fame. The psychiatrist did not stop with the symptoms of delusion but instead tried to override it and get in touch with emotional conflicts which were probably present behind the delusion.

I will summarise the second clinical case, which is the complete opposite to the first one, from the autobiographical book by the American author Ken Steel (2001). This is the biography of a person who was chronically suffering from schizophrenia with severe persecutory hallucinations for over 40 years and had tried several psychiatric hospitals in the USA. In this book we can find a shocking declaration of the non human psychiatry which results from a medical model, in which we can not even find a bit of psychological approach or understanding to the patient.

Between non specific and specific contributions of psychoanalysis to psychiatry

I mentally devised a plan by which I thought that non specific contributions of psychoanalysis to psychiatry were easily understood in a larger psychoanalytical culture, that I

tried to elucidate upon in the previous chapter. I perceive the specific contribution of psychoanalysis to psychiatry when it comes to direct psychotherapeutic work with patients which I will talk about in the next chapter. There is also an intermediate contribution on which I will focus on in this chapter. I am mainly referring to various types of supervision in different psychiatric institutions and on various psychiatric services , which belong to psychoanalytical thought or culture.

I must explain that when we are talking about supervision in various psychiatric institutions, we are talking about a wider and different concept than the one we see in the classical supervision in psychoanalytic proceedings on a singular patient, even though the two also have something in common.

This practice started in Italy in the 70's and has developed lately; singular psychiatric teams who were working in psychiatric institutions asked for an external observer, that is for a psychoanalyst, who was not included in the team and had no other connections with that institute and who could help them with their difficult task. Today we are still naming this relation as "supervision".

In traditional individual supervision (like for example in training a young candidate in psychoanalysis) the setting is much more specific and the candidate is also better prepared for this kind of setting because he has at his disposal a personal analysis where he can thoroughly examine his own personal problems and conflicts, which are being provoked by work with the patient. Issues in these psychiatric supervisions are much more complicated and undefined. The psychoanalyst has to come face to face with difficult clinical material brought by a group and not by a single therapist and that material is already fairly complicated. Besides, members of this group are usually not psychoanalytically prepared to facilitate the supervisor's task or to focus more on clinical problems set up by the patients. That is the reason why psychiatric operators (psychiatrists, psychologists, social workers and nurses) often bring personal problems and issues within the supervision in order to put the supervisor in a more therapeutic function and transform the supervision into a therapeutic group. As far as problems with this supervisions and functions of these supervisions are concerned, I would like to connect to reflections regarding this topic showed by the colleague Bolognini and his

colleagues (Bolognini-Trombini 1994) (Bolognini-Mantovani 1999). The basic characteristic of supervision should be the formation of a psychical space, which encourages the way of thinking and reflection about what is happening with the patients. Several observers claim that psychiatric approach is mainly based on practical and concrete intervention, on action and that this practice therefore allows little reflection on the meaning and the sense of this concrete action. Supervision instead should dedicate itself to this moment of reflection. The motivation of a psychiatric team to ask for supervision and therefore for external help, can be of different nature. Working with very difficult patients and pathological cases every day can put the psychiatric professionals under enormous pressure. The peak of a crisis is exhaustion or burn out. Less serious examples of crisis are depressive feelings of inferiority and inability in curing difficult patients (with temporary maniac omnipotence mechanisms as a defence reaction to depressive feelings). We can also take into consideration the loneliness of professionals and sometimes major dissatisfaction between them or singular groups of workers. In these cases, supervision is rather "therapeutically" orientated. Another aspect of the team crisis could be the fact that the team's creativity and focus has completely drained away and that they are working mechanically and without motivation.

What should the function of this supervision be? As we mentioned before, supervision should stimulate meditation and deep reflection about clinical cases brought as material by professionals. It should create a space for a third psychoanalytical dimension compared to a concrete, dyadic one, which is carried out by psychiatry also under the influence of regressive inclinations of difficult patients. Besides, this specific psychoanalytical contribution, supervision should be a moral support to professionals, so that it would increase the value of their work, would build a healthy and creative team pride and possibly reduce conflict dynamics which seriously threaten team work and loss of energy and therefore accelerate burn-out.

At this point I recall a problematic situation in a Center for the Mental Health that an experienced male nurse relayed me a short time ago: a patient in a severe psychotic crises physically assaulted a young female nurse who was just at the beginning of her working experience. The nurse was emotionally traumatised and was expecting a word of comfort or at least a verbal mention about what had happened by the head physician. But he totally ignored

what had happened and he firmly put himself in his usual "bureaucratic function" saying that this kind of accidents are part of the psychiatric work and that he is there to cure patients and not nurses. The older and more experienced male nurse commented that with this kind of experience the young colleague might sooner or later be a candidate for burn-out.

In the last decade, in several countries of Western Europe, there has been a tendency for the psychiatric care also of quite difficult patients not to lean mainly on psychiatric hospitals and quite long hospitalisations but to gradually transfer this treatment to smaller, more agile and more elastic structures, which should create a richer and wider net of answers on various problems, that are represented by the psychiatric patient. Previous obsolete psychiatric hospitals have been reproached for frequently causing additional negative iatrogenic effects and additionally causing a chronic regression of patients. Smaller structures such as centres for mental health, consulting clinics, day-hospitals, psychotherapeutic and rehabilitation centres, psychotherapeutic and residential communities started to emerge. Similar structures started to develop in Italy in the 70's, under the supervision of the psychiatrist Basaglia, which lead to the psychiatric reform that was legitimated in 1978. These institutions are divided according to defined geographical areas. This reform is partly based on the French model "La Psychiatrie de secteur".

Psychodynamic psychiatry speaks in favour of different kinds of psychiatric structures since it is based on the principle that even difficult patients, regardless their diagnosis, have very different personal and therefore psychological needs and we therefore have to respond to these needs therapeutically, with different approaches and means, thus also with different structures. The traditional psychiatric hospital, which was mainly based on a biological culture, was giving one-way, stereotypical, biological and careful answers so that was additionally emphasising the patient's passivity.

On the whole, the concept of psychological level of maturity of a person is present in psychodynamic psychiatry, independently of its pathological symptomatology. The psychodynamic approach examines, how mature or regressive a person is, how structured and non structured one is, and how proficient one is, in spite of one's pathology, of a personal psychological, social or existential independence, or is not able of all this and therefore has

recourse to primitive, sheltering human relations which can become wholly symbiotic or autistic.

Based on these various levels of personal psychological maturity or non maturity, psychodynamic psychiatry has tried to elaborate appropriate therapeutic answers and specific suitable psychiatric institutes for them. These kind of concrete experiments took place in Italy, in Lombardia (Vigorelli 1994), a very interesting network of various psychiatric institutes was set up in France, in Lyon, under the guidance of Marcel Sassolas (1997).

In these organisations of psychiatric care network is situated the psychiatric department (settled in some hospital) for patients in the most "regressive" stage, meaning that this department should be addressed to the most regressive and severe phases of psychotic pathology, where the Ego of the patient is in a total collapse or acutely dissociated, fragmented and confusedly incapable. In this phase the patient needs intensive general care, almost maternal in nature, as if he was a baby, he needs psychopharmacological therapy and everything possible to hold on to and gradually help him reorganising his decaying and falling Ego.

On a more advanced level of psychiatric institutions, we come across several intermediate structures, which should therapeutically work on a more mature level and should correspond to more mature phases of psychotic pathology. When the hospitalisation is over, because we were able to bring the patient out of the acute or regressive phase, the patient will be taken care of in a structure which works on a higher level, where the therapeutic interventions will be on a more mature psychological level. We can here take into consideration various forms of territorial centres for mental health, day-hospital, consulting centres, therapeutic and residential communities. These are mainly addressed to "chronic" patients.

Specific contribution of psychoanalysis to psychiatry

Here I refer to specific therapeutic contribution of psychoanalysis to various heavy psychic pathologies, which are mainly treated and being taken care of by psychiatric services and professionals. Stopping on psychotherapeutic approach to various psychical pathologies would be too difficult and time consuming. I would personally like to focus on psychotherapeutic approach to psychotic (schizophrenic) patients and partly on borderline patients who can sometimes become unbalanced in a psychotic state. For other pathologies like affective psychosis (depression, manic crisis, cyclothymic pathology) and several other personality disturbances, Gabbard (1994) puts the emphasis on the importance of psychodynamic and psychotherapeutic approach, because according to various researches, integrated approach is shown as pharmacological and the psychotherapeutic seems to be much more efficient than the pharmacological approach alone. Time and frequency of hospitalisations are usually being reduced, patients are generally dealing with their issues better and they generally better manage their pathology. As far as psychosis and heavy borderline pathologies are concerned, I would just like to generally elucidate the theoretical approach with which we can operate today. Later I would like to focus on technical therapeutic approach. If we start from Freud (1923) we can already find a theoretical definition of psychosis which became a fundamental starting point for the later debate on the psycho-dynamics of psychoses. Freud thought that in psychoses the libido alienates from the object and auto-erotically reaches its own Ego and therefore interrupts relations with the external world. But we know, that Freud was very pessimistic towards therapeutic psychoanalytical proceedings of psychoses, as patients with such a "narcissistic" pathology were not able to create with the therapist an appropriate transference. Among early psychoanalysts, who were dealing with psychoses, Federn (1952) was pointing out the deficiency of the Ego. This pathology or defective functioning of the Ego was later deepened by the followers of the American movement of the psychology of the Ego, as for example Hartmann (1953) and E. Jacobson (1967).

A very important contribution to the studies and understanding of severe pathologies, and therefore also psychoses, was given by M. Klein (1948) and her school, when she deepened the initial phases of a child's psychological development and connected them to

more primitive functioning of our mind in cases of heavy pathologies. Schizo-paranoic and depressive positions, which represent a sort of physiologic psychoses in a little child and his "recovery", are well known in her theory of psychological development. This recovery is possible because within in a child's nature there already is a tendency to mature, indeed with the help of an adequate human environment. What for many is hardly acceptable in M. Klein's theory nowadays, is the fact that she placed a great deal of importance on aggressive instinct (death instinct, primary envy), which should be very strong at the beginning of the child's life. As psychotic pathology is an expression of regression in very primitive child's levels of the mind's functioning, the aggressiveness component (especially the oral one) should also be present in psychoses according to this concept.

Later, in Italy this was happening in the 70's, theories which would emphasise the development of the "self" from the birth on, through object relations in the process of symbiosis, separation, to individualisation and later higher levels of psychic development, were brought forward. These theoretical schools had different fonts. Winnicott (1965) was the leader of this stream in England, M. Mahler (1975) was an important representative of this movement in America. Among significant analysts who belong to this movement and who spent a lot of time dealing with psychotics' psychotherapy we include Searls (1965), Ping Nie Pao (1979) with his co-workers, and Giovacchini (1986,1989) in America and Zapparoli and his school in Italy. With these theoretical approaches the whole of psychoanalysis is moving from classical energetic-structural theory into the theory of object relations, where the human environment becomes very important and responsible for a healthy and good psychological development of the child.

I would particularly like to stop at Pao's theory who set some important theoretical and therapeutic guidelines for psychoses' proceedings. In his opinion, later candidates for psychotic decompensations have, already in very early childhood, that is in the symbiotic development phase, very negative and traumatic experiences which will influence later psychological development in an overwhelming fashion. This kind of child will not internalise a primary object (of the emphatic mother) which is good enough, but will internalise experiences of emotional deficiency, bad temper or even psychical pain. In this case the relation with the object will

always be painful and conflictual: the need of the object will always fight with resistance to the object. This will be the basis for later psychotic's ambivalence for the object, when he will aim to and reject it at the same time. Zapparoli (1979) claims that a psychotic person is expressing the need, that he has no need (of the object). People with this negative experience in childhood will be more vulnerable and fragile under internal and external pressure and might go astray in psychotic decompensations when the Ego totally gives up and fails.

Under internal and external pressure these people will go astray in acute psychoses' panic reactions when their Ego will totally give up, will collapse in dissociation and fragmentation because they don't have enough solid experiences of solid grounding and a good object inside (Winnicott 1965). As a consequence to this threatened situation to the Ego, these people frequently act with aggression mechanisms because there is a little space for libidinous manner of expression. Since this aggressiveness is the only possible power in such difficult circumstances, it expresses a struggle for psychical survival and is therefore not a primary aggressiveness as the followers of Klein's school conceived. These people will certainly have serious problems in the further development in the sense of separation and individualisation as well as in reaching higher phases of maturation like oedipal level, processes of symbolisation and higher psychological functions. Bion (1967) would say that in a psychotic the function alpha is strongly involved and thus transformation of beta elements into alpha does not work well.

The patient very often experiences decomposition and dissociation of the Ego in the acute psychotic phase as a catastrophe, as if it was the end of the world. When this kind of patient experiences a number of these psychotic crises he passes into a sub-acute and chronic phase in which he tries to re-establish some defence mechanisms in order to protect himself from these violent attacks. Pao thinks that productive symptoms, like hallucinations and delusion, are the expression of an automatic psychical system's remedial function, when our psyche is trying to create an alternative internal world and together reaching a continuity (even if pathological) in its own Ego.

Some of the more modern psychoanalysts (Sassolas 1997, Correale 1997, 2000) are emphasising a badly structured self and Ego in psychosis (that is to say a deficit) and

pathological object relations (big conflict). Such fragile and vulnerable Ego (maybe already biologically conditioned to some extent) is not able to re-establish a physiological and normal filter against internal and external irritations. That is why this vulnerable Ego could react with panic in stressed conditions with the decomposition of the Ego as if these situations were very traumatic. As far as this psychotic trauma and fragility of the Ego are concerned, two patients who are around 30 years old and I have been following for a few years come into my mind. In the last years they have both already had, in a shorter period of time, two psychotic decompensations. They are now out of the acute phase. With the first patient I am struggling to somewhat at least reinforce his Ego which is constantly threatened and under the influence of hallucinations and delusion. It is very often impossible to distinguish from his hearing persecutory hallucinations and external unfriendly voices, it feels as if he was all perforated and unable to establish a border between the external and internal world. The second patient, who is more stable and out of acute psychotic decompensation, is trying to defend his fragile self trying to live as carefully and sheltered as possible. Even a small change in the work environment makes him uneasy. He is obsessively clasping on some established order.

With regard to pathological relation with objects we could furthermore say that a psychotic person is not able to have any physiological dependence and independence from the object and neither any normal distance or vicinity with the object. In this sense he oscillates between an excessive nearness, when he is looking for symbiotic dependence, and excessive distance when he is trying to digress from or destroy the object (at times also with concrete physical attacks).

Correale (2000) lays also stress upon traumatisation or traumatic experiencing of a psychotic person in the sense, that he is living all of his experiences traumatically and he is therefore feeling continuously threatened and in danger because of his vulnerable self. This patient will, in a long term or chronic development, develop a very strong or primitive defence mechanisms which Sassolas (1997) was mainly dealing with. After this observation two defence mechanisms should be present in psychotics, that is the mechanism of emotional freezing (Resnik 2003) and the mechanism of psychic emptying (evacuation). With the first mechanism the psychotic freezes all emotional and cognitive perceptions, shelters in symbiotic

relations and no longer allows himself to learn anything from any experience. With the mechanism of emptying the psychotic tries to save himself with the help of projections and projective identification of several psychotic contents. Psychical activity for a psychotic person is according to Sassolas arduous and unpleasant, maybe even painful, full of uneasiness and terror. The psychotic tries to prevent psychical efforts and uneasiness with the mechanism of evacuation. These defence mechanisms additionally weaken psychic abilities, so that higher mental functions such as symbolic and abstract mental processes decay. Also speech function frequently fails. A psychotic frequently acts on the basis of concrete thinking which could be interrupted by bizarre elements (Bion's beta elements) or expresses himself with actions that replace speech and thought (let's take Racamier's (1980) concept of "the speaking act" or the concept of "exteriorisation" in Volkan (1986) and Sassolas 1997).

Sassolas dedicates a great deal of attention to these drastic defence mechanisms, because they work paradoxically: even though they are being activated with the intent to protect the whole psychic apparatus, they additionally make it more poor and worsen its functions. In extreme cases the psychotic will try to reach a sort of psychical anaesthesia when he will close himself in his delirious autistic world and will try to devalue human beings on non-alive objects (Searles 1965, Zapparoli 1979).

If we have a glance at the borderline pathology, we have to emphasise a lighter form of deficit of the self and the Ego and a lighter form of pathological object relations. Also in this case the Ego is relatively immature and fragile, uses quite primitive defence mechanisms, the identity of the person is still very disorganised and incomplete, a more balanced and integrated personal structure is missing. This person is under the effect of severe and difficult to command impulses and moves from idealisations to persecutory experiences, an internal disturbance and a sensation of emptiness prevails because this kind of patient is trying to compensate with various impulses, such as for example an excessive sexual expression or drugs. As far as object relations in borderline persons are concerned, Searles (1986) stresses great difficulty in the process of separation and individualisation, Correale (2001) points out a strong disturbance at "fundamental emotional state", which causes a continuous instability in borderline patients, the feeling of lack of continuity and internal "traumatisation". Due to this

disturbance and internal traumatisation, the person will lose his experiences and events from his memory and will "bleed psychically" (Correale 2001). It will also be difficult for him to organise perceptions and cognitive comprehension. This kind of person hardly connects observations, mainly lives on details, he has a marked episodic and not semantic memory. Under the pressure of stress, this person is likely to go astray in psychotic decompensation when the Ego will give up even more.

Therapeutic approach to psychoses in psychoanalysis

In psychoanalysis it is generally widely known that it is difficult to treat psychotics psychotherapeutically in a traditional or classical psychoanalytical setting. This is mainly suitable for neurotic patients, where the level of the Ego structuring is quite mature, where there are no deficiencies of the Ego, where the patient has quite the ability for self observation and for introspection and where he is able to experience quite regressive levels and dynamics of his interior, yet under the control of his Ego and in a normal relation with reality. As we have already seen, a person with psychotic disturbances is on a fairly primitive level of psychic activity, his Ego is badly structured, his relation with the reality is quite unsteady, so that he badly distinguishes the external world from the internal. From this premises hence follows, that for these patients, who act and live on quite a pathologic level, we have to prepare and organise a different psychotherapeutic approach from the classical setting (with 3-4 sessions per week on the couch). As for the concrete, outside setting, it is generally advisable to see this difficult patients regularly in front and not on a couch which could additionally aggravate their regressive state. We also have to adapt the sessions carefully according to the patient's needs. We usually start with a lower attendance (say one session per week), later we can increase attendance (on 2-3 or more sessions per week). It is very important that at the beginning of psychotherapy we are being very careful about the appropriate distance to the

psychotic patient since such a patient is very sensitive and vulnerable on this matter. We said that a psychotic has a very fragile Ego and a very pathological and conflictual relationship with the object, we therefore have to approach him very carefully, discreetly and patiently, wait for him to acquire enough trust in us as therapists in order to maintain a satisfactory therapeutic collaboration. In the classical setting we emphasise a very methodological principle, that is that the therapist has to be neutral and in position of abstinence. With the psychotic patient we have to be more careful about the appropriate therapeutic distance, not too close, nor too far from the patient.

In psychotherapeutic procedure it is very important, even more than in the neurotic patient to present ourselves as people who are authentically interested and care about his psychological experiences and needs, who carefully listen and try to understand his psychological experinces and enrich him as a person regardless of his pathology.

There is also another difference that we have to point out between psychotherapeutic approach to the psychotic patient in comparison to the neurotic patient: with the psychotic one we will have to work more as a new object, sometimes as a concrete object, parallel with the function of the transference object. This is due to the fact that we will have to help the psychotic, as if he was a child, to gradually build more mature psychical structures, especially as far as psychic rappresentations and processes of symbolisation go, and in this sense we will have a more constructive and less analytical function.

Generally speaking ,many authors point out that in severe pathologies we have to work more as a new object and make an effort to build a good relation with the patient with the most emphatetic approach, that we are offering to him this new good experience, and only later we will be able to expound some transference dynamics. The psychotherapeutic approach will thus take course much more on a positive emphatetic relation (corrective experience) rather than on the analysis of transference happenings. These will become possible when we will already manage to build up some Ego.

Searles (1965) and Winnicott (1953, 1965, 1989) have quite clearly defined how the therapeutic approach to severe pathologies and therefore to psychoses should be. Searles (1965) claims, that a psychotic patient should be offered a good "therapeutic symbiosis" in

psychotherapy, if this kind of patient did not experience or experienced a problematic or pathological symbiosis in his childhood. Winnicott (1989) suggests a similar thing when he is saying that the therapist should act with a regressive patient like "a good enough mother" with a little child, that is to say that the mother puts herself on the child's regressive level, adapts to him and satisfies his physical and mental needs. This kind of mother can afford to temporary "fall ill for physiological psychosis" with the fact that she adapts to the regressive child's "psychotic phase" and slowly returns to a more mature level of psychical functioning when the child is growing up. The therapist, who is psychotherapeutically dealing with the psychotic patient, should permit himself something similar, thus to emphatically come closer to the regressive level of the patient without being affected by or fall ill for psychoses. This therapeutic symbiosis should have the function and the intent that this positive experience strengthens the patient's self and Ego, to interiorise the good object and the good relation and thus to let this therapeutic process easily direct him to later phase of psychological maturation, as for example the phase of separation and individualisation, and indeed, a larger integration of the Ego.

In psychotherapy some authors suggest, with a psychotic patient, to seek therapeutic alliance with the healthy part of oneself and from this position more effectively help the patient to control his psychotic part. This may be more suitable in some specific phase of the therapeutic process but I am personally more inclined to believe that we have to treat both parts of the person in a more balanced way: either the healthier part or the more mature part or the more pathological or regressive part.

As far as course of the psychotherapeutic process is concerned, Zapparoli (1985) claims, that with the help of therapy, some psychotics can overcome symbiosis and attain quite a satisfactory level of separation and individualisation. In other cases we will only partly reach this objective with the patient. There are also cases of malign psychoses when the patient is not able to get out of the symbiotic dimension at all.

Schematically I could say, that there are two very critical moments in the psychotherapy of a difficult patient, which works on a psychotic level: namely, as we have already mentioned, the first part of psychotherapy is very critical when we must cautiously

create an adequate setting, a suitable relationship and seek therapeutic alliance. The second critical moment occurs, when patient and therapist are trying to overcome the therapy's symbiotic phase and move to a greater separation and individualisation. Some patients succeed in attaining this passage, others do not. In any case this phase occurs with very turbulent transference and counter-transference experiences, because on this course, the patient will experience, in the transference, all of his uneasiness, fears and will activate all regressive defence mechanisms. It is possible that at this point the patient experiences "transference psychoses" when the therapist will represent a menacing role for him, because he will hardly accept the therapist as a separated object if the symbiotic connections to him are still very strong. If the patient manages to overcome this turbulent phase, his Ego will be stronger and will reach a greater independence and maturity. If this passage doesn't occur the patient will try to manipulate with the therapist with his pathological narcissism or the therapeutic relation will break off. For such difficult patients every attempt of separateness from the therapist is a big narcissistic wound, they experience every movement in this direction in a very persecutory and menacing way at a very primitive and extreme mechanism, saying "if the therapist is not with me completely, on my side (in symbiosis), it means that he is against me".

Counter-transference therapist's experiences with difficult-severe patients

As a general statement we have to take into consideration the fact that psychotherapeutic work with psychotic patients is quite difficult and demanding in all senses. Whoever is psychotherapeutically dealing with these difficult patients knows, that he might experience very difficult and turbulent emotional states on the counter-transference level. The patient could burden or provoke him with heavy emotional experiences. The therapist will get

in touch with very regressive psychical conditions and needs, him alone will be the target of strong projections and projective identifications, he will interact with aggressive object relations, he will experience strong symbiotic patient's needs or he will experience the patient's need to push him in the role of a non-alive object. Furthermore the patient will sometimes try to control him with his omnipotence, projective and introspective identifications might be changing quickly as well as the internal psychotic's world changes very chaotically. At the time Zapparoli suggested that the therapist who is dealing with psychotics, should carry out an additional personal analysis in which he should dedicate special attention to his narcissistic vulnerability and to his "psychotic" components. I personally think that the therapist dealing with psychotics, should strongly deepen, at least with his self-psychoanalysis, in his more primitive and regressive mechanisms. Due to the above mentioned reasons it is advisable that the therapist doesn't overburden himself with a great number of these difficult patients and that he does not follow them all at the same time. It is as well important that the therapist is not left alone in this job of and that he is in every way connected to his colleagues with whom he can discuss his counter-transference and other therapeutic problems. I personally have a very precious experience with a group of colleagues from the Centro Veneto di Psicoanalisi who I have been collaborating with for over 15 years and with whom I have approached with difficult pathologies and we have mutually aided each other in this demanding task. It is also necessary that we are in touch with a psychiatrist or a psychiatric institution which should follow the patient from the pharmacological side and should intervene in case the condition worsens or passes to a more acute crisis. We also have to continuously be aware of the fact that our psyche, that is the therapists' psyche, is sometimes very fragile and when in touch with difficult patients our clarity of mind might suffer too. Difficult patients will often push us in a dyadic relation, we therefore need a third element (also a concrete one), which could help us to keep on a triadic level too.

Giovacchini (1989) and also Zapparoli (1979) presented some specific elements in counter-transference with difficult patients. Giovacchini says that difficult patients will frequently attack the setting (that is the external and also the internal therapist's setting) in quite an intrusive way. This is due to different reasons: the psychotic will hardly comprehend

and understand a certain neutrality and simultaneously the therapist's availability, then he will hardly know how to regulate the right distance with the therapist and additionally he will carry out in the transference with the therapist some intrusive object relations that he is carrying inside from his own experience.

Zapparoli (1979) claims that in counter-transference with the psychotic we can frequently experience the feeling of fear and boredom. The feelings of fear are awakened by the psychotic's aggressive elements, which are very important for him and expression of the only possible life force. The feeling of boredom is caused when he tries to put us on a non-alive object level because we could threaten it with our life energy.

It is very difficult for the therapist to maintain a balance between the emphatetic approach to very regressive level of psyche in a psychotic person and at the same time maintain an analytical capacity on a higher triadic level which could lead the patient from more regressive, primitive actions of the psyche to more mature and healthy structures. It is also difficult for the therapist to correctly measure out his function of transference object.

I would also like to emphasise the burning and paradoxical therapist's role when dealing with psychotics. Sassolas (1997) says, that we accurately have to distinguish between deficiencies of the Ego and additional primitive defence mechanisms, like freezing and evacuation, because they additionally have a deficient influence on the psyche's role. At this mechanisms the therapist paradoxically has a nearly impossible role: he should try to give back to the patient his mental and emotional capacities, which the psychotic is trying to get rid of. In this function the therapist will have to be very cautious and careful.

As Arrigoni Scortecci (1988), Gabbard (1994) and Sassolas (1997) suggest, there is also another difficult and nearly ambiguous role that the therapist should carry out in psychotherapy with psychotics: not to put too much emphasis on his therapeutic role, not to appear too firm and proficient in his actions and observations, try not to be narcissistically brilliant with his interpretations or intuitions. He should show his personal spontaneity more, more human dimension and less professionalism, if needed also human fragility, not to hurt or even put down with an exaggerated professional approach an already so narcissistically fragile psychotic and consequentially provoke narcissistic anger or envy.

Some clinical situations

Firstly I would like to describe the case of a 25 years old female whom I have psychotherapeutically treated for about 3 years. Before and during psychotherapeutic treatment the young lady has had three acute psychotic decompensations which required hospitalisation and continuous healing with psychotropic drugs. The patient comes from a good family (her mother is a social worker, her father is a dentist, her younger brother is a fairly good student). I had the impression that both parents were emotionally cooler and their strong life values were productivity and success. The patient finished high school for economics and was later employed in several companies as an office worker. At the same time she was also very active in sports (skiing and above all, handball). Her handball team was very successful and she was one of the best players on it. Because of a serious accident to her knee which occurred during a match, she was forced to give up playing. As we could reconstruct later on during therapy, this accident was a severe narcissistic wound on an unconscious level which caused innumerable pathological reactions in the patient. She started taking soft and synthetic drugs, she was overdoing it with alcohol. Later on she "pathologically" fell in love with a very successful and popular skier who made his name on the international level. This amorousness slowly grew over into an erotic rambling dimension which alienated the patient from reality. Even if this young man had often affirmed that there was only a friendship between them and periodically a sexual encounter as well, my patient was unrealistically convinced that this man is madly in love with her but there are a number of hostile people who are preventing him to freely opt for their lasting union. She started following him because she was afraid of losing him. She would call him also 10 times a day, she was waiting for him in front of his house for hours, she would turn up at his training sessions, she was controlling his life so that he felt tormented and often threatened her with the police. Her condition got worse with

hallucinations, so that her total confusion brought her to hospitalisation and psychiatric healing. Psychotic crisis similar to these ones repeated twice in the last years.

As far as I could understand, together with the patient, in this psychotherapeutic treatment was, that her personality was still very immature and badly prepared for frustrations but with very ambitious expectations. In her erotomaniacal experiences, she has always looked for very successful partners who represented an idealised object and who should heal her narcissistic wound with their love. The patient could also narcissistically come to life again in the shadow of this idealised object. In psychotherapy we tried to get through her narcissistic vulnerability and give her a chance to develop her own self in a more mature way, to easily accept separation, loss and also frustrations that life sometimes experiences.

The second clinical case is quite unusual. It consists in psychotherapeutic work with a father, who has a psychotic son, who is over 20 years old. This father addressed to me two years ago because he was in a strong personal crisis (lack of understanding with his wife, difficult relations inside the family) and because he had significant problems with his eldest son and did not know how to direct this relationship. The therapeutic work with this father was carried out in a very strange and singular way: on one side it dealt with overall difficulties of his personality and his relations, on the other side we tried to concentrate on the problem of his son and to think of what would be more suitable plan. The father admitted that many times he had been too severe and maybe too demanding of his son. On the other hand, the son always showed an extreme inadaptability, non co operation, stubbornness, laziness towards school and studies. These problems became larger in adolescence: he dropped out of school, rejected any activity, joined a group of young anarchical protesters (so called: "disobedients"), who organise protest meetings, occupation of public buildings, constantly took light drugs and generally laze. Their behaviour was framed in an ideology, which totally rejects our social regulation, thus the purpose of their behaviour was to destroy this system. The son was already showing signs of pathological development in this phase, in a direction of a regressive inertia and somewhat persecutory dimension. It was not possible in any way to have a more concrete influence on the son in this phase (also because he had a strong support in his group), even though the father had tried to get closer to him very delicately, understand

him, help him and somehow stand by to him. Thanks also to our psychotherapeutic work, in this period his father showed a great deal of patience and tolerance which he had not before. His son's situation gradually got worse in the sense that he was slipping in a more evident psychotic paranoiac dimension when he started to be afraid of everything: he was afraid of food, saying that it could be harmful or poisoned, he removed all objects from his bedroom, because they could emit harmful substances, he wouldn't wash himself or get changed anymore, he was dirty and ragged like a homeless person. When additionally hallucinations occurred, his parents managed to get him in touch with psychiatric services and hospitalise him at the psychiatric division. He has been under psychiatric care for over a year already, he is being followed by a very efficient team. The patient is causing them a lot of trouble, because as a person he is generally not too co-operative, thus his rehabilitation has been difficult and arduous.

In psychotherapeutic proceedings with this patient, we worked on quite a number of problems of personal character and at the same time we dealt a lot with the patient's son. A significant contribution of our work to the son's problem was the fact, that we better defined the son's problems and pathology which were arising a lot of confusion and different repercussions in the whole family (e.g.: The mother of this ill son was thoroughly quite convinced that he is just lazy and is making a fool of everyone). Our work also helped the father to get closer to his son in the best way possible and that he actively, but not aggressively, looked for psychiatric help when it was necessary.

Another problem was brought up a short time ago in our monthly seminar in Ljubljana (Slovenia), where an experienced colleague presented the case of a 30 years old female patient, that she had been following for 14 years, who had already had some psychotic decompensations and who mainly acts on a borderline psychotic level. This patient has achieved a quite good level of activity with my colleague, she is much more structured and and my collegue was internalised, as therapist, as a good, reanimated object. But in psychotic patients this is frequently not enough to build a permanent and stable personality structure and to transfer successes in psychotherapy to a wider psychic space and to the external world too. This patient is not yet able to reproduce her achievements in the every day life. For this

kind of problems it might be suitable to intervene in a further manner, with group psychotherapy, therapeutic communities and similar. I personally do not have experience in this field but many authors speak in favour of this kind of group approach for psychotics, as for example Sassolas (1997), who says, that individual approach for psychotics is often hard to accept and difficult to carry out, because they soon get involved in severe dyadic relations from which they find it difficult to get out. Group approach is in his opinion less menacing for the psychotic's very vulnerable narcissism.

In contrast to this kind of experience, represented by the before described patient, I also have very positive results with psychotic patients who required much less effort. In relation to this, I have the case of a 30 year old female patient, whom I have had in psychiatric and psychotherapeutic therapy for two years and who had already suffered from chronic auditory hallucinations. As far as patients with auditory hallucinations that I have been treating in the last years, I had the impression that these patients have a pretty reasonably structured Ego, and their problem is, that part of their personality, which appears in form of a sadistic Super Ego with hallucinations, is entirely non integrated and divided from the other personality. In the case of this patient, her state had already strongly improved after two years of proceedings and maybe, as for psychotherapy, with a quite non-specific approach.

The psychotic world is varied and is still putting to us innumerable unsolved questions and new therapeutic challenges. Even if the psychoanalytic approach does not yet solve all of the problems in this field, I think, that it is very important and precious to understand the world of psychotics better, to get closer to it and to awaken the possibility of a bigger integration of some parts of the patient's personality, even the more pathological parts, which are still very stigmatised today.

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