Technical Problems with Severely Ill Patients

Decio Tenenbaum

Good afternoon. First of all, I wish to tell you my plasure in be here to discuss with you about psychoanalysis of severely ill patients. The ideas I will present here were developed in the book "Investigating Psychosis Psychoanalytically", launched in Brazil in 1999. I will therefore limit my approach to psychotic patients.

As stated in dictionaries, technique is a conjunction of processes through which a function is carried out. Technique can also be used as a mean of implementing something. However, we are here to discuss problems, which may arise, when we try to do Psychoanalysis on the more psychologically disturbed patients.

As Horacio Etchgoyen well defines, Psychoanalysis is "a new technique, introduced by Freud [in the therapeutic arsenal]". Quite adequately, he shows that the psychoanalytical technique has been constructed as of theoretical elaborations which stem of Freud's clinical practice: each new theoretical step (trauma, repression, infantile amnesia, transference and from there on) implied in changes in the therapeutic procedure, that is, in the technique.

All those who have tried and those who continue to treat psychoanalytically psychotic patients persist in the Freudian methodology, contributing that the psychoanalytical treatment does not become a ritual to the point of pushing its agents into forcing patients to fit into a procedure and spending a long time of the clinical time examining the difficulties of the patient in subjecting himself to the pattern.

Freud believed that the mental dynamics was exclusively moved by conflicts and contradictions (from the person with itself, the person and its desires, the person and its external and internalized objects, from the person with society and the person with its culture), but development of psychoanalysis with severely ill patients have shown that the conflict is not the only motor of mental dynamics. Countless authors have already mentioned that affective and cognitive deprivation can be as pathogenic as certain conflicts. As a matter of fact, they are more pathogenic than the conflicts. Unfortunately, a revision of the psychoanalytical pathology in the sense of embodying mental states related with psychological deprivations, which may branch from failures in significant human relationships, has not yet been made.

Quoting only two authors, Michael Balint and Jaques Lacan dedicated themselves to the study of initial relationships, but not only from the perspective of the conflict theory as did the majority of the psychoanalysts (1). Balint and Lacan discriminated very well the different levels of mental operation and consequently of the psychoanalytical treatment: on the Edipian level the motor of psychopathology is the conflict and the objective of the treatment is the solution of same, on the pre-Edipian level psychopathology expresses a basic fault (2), the treatment of which, a true healing process, almost always leaves a scar (some kind of psychological shortcoming). Although both authors present different understandings as to the nature of this basic privation – while to Lacan the failure is related to the paternal function, to Balint it derives from the discrepancy between the bio-psychological needs at the time of the structuring of the mind and the care, attention and affection, material and psychological received at that time from those responsible for the child – to both the consequences are the same: a state of non-structure of certain mental functions (differently identified by each author), only partially reversible.

The fact that psychotic patients do not develop demands, questions, but states similar to addition, shows the deficiency of the theory of conflict to explain psychosis. With the exception of cases of very early

child psychosis, in which I do not have any experience, in my therapeutic contact with the mentioned psychotic patients I always came across the fact that the psychotic does not suffer due to mental conflicts. If he has them, logically as all other human beings he does have them, these are not (the conflicts) what make him ill. In dealing with these patients I have found, with remarkable regularity, persons who end up finding ways not to suffer anymore with their lack of support and basic psychological lacks, almost always expressed in a most peculiar way (delirium) which tries to overcome not only their failures, but also their grievances, resentments and deep sorrows related to faults by those responsible for their raising. The worst is that these are not only faults from the past. As they usually continue living very much attached to these people, failures are repeated thereby inducing repetitive psychotic crisis and/or a progressive alienation regarding the world.

I hope that, once the possibility of non exclusivity of the conflict theory to explain all mental diseases is open, it does not become mandatory anymore to think that the technique and therapeutical objectives of psychoanalysis of psychotic patients should be the same as those in psychoanalysis of neurotic patients. After all, no doctor would recommend the same medical treatment for pneumonia and lung tuberculosis only by the fact that both assail the lungs. Unfortunately, psychoanalytical institutions do worse than this supposed and mistaken practitioner does: if the psychoanalyst does not employ the same technique with all his patients, he either is not practicing psychoanalysis or is no psychoanalyst.

Due to the strength of the conflict theory, and in spite of what Freud taught us on the important work of the elaboration along a psychoanalytical treatment, the interpretation has been considered, for many years, as the psychoanalytical intervention par excellence. However, every psychoanalyst who has treated psychotic patients has had the experience that the interpretative work became unproductive, having to stop or postponed in given moments or even during long periods. Enough importance has not been given to the obligation every analyst has to evaluate and adequately establish the rhythm in which new information are conveyed to the patient (generally through interpretations) and the necessary time that the same are integrated or elaborated (3). This is of crucial importance in the treatment of psychotic patients.

The occurrence of algic episodes, vague indispositions or even anguish (4) is generally a manifestation of mental overloading. In the more fragile egoic patients, mental overloading usually expresses itself through acute states of mental disorder (be it an ample disorganization, the psychotic outbreak, or be it a partial disorganization as the identity disorganization, the depersonalization, or the disruption of cognitive aspects of reality, the derealization) or small moments of mental confusion. In these moments, the psychoanalytical interpretation, as well meaning as it may be, tends to aggravate the mental overloading, considering that every new information represents more stress to the mind.

Therefore, in the state of disorganization and/or mental overloading, it is more indicated to restructure the elaboration capacity of the patient before supplying him with more information on himself, of his internal world or even the external world. Accompany the elaboration process (even if delirious), if possible supplying him with several cognitive elements about the process he is going through and guide lines in front of external and internal realities (as the situation may require), will lead to relief of the intrapsychic tension of the patient. Acting this way, the moment to help the patient to meet with his unconscious motivations, which contribute to the disarray of his mind will also arrive.

In neurosis, generally, the unravelling of the conflict favoured by the interpretation of the unconscious matter eases the intrapsychic tension as the processing (elaboration) of information was hampered by the absence of fundamental information or for some environmental tension, that is, in the interpersonal relationships. Restarting the information processing, one observes the reduction of tension within the system and deviations, the variations of the process which was applied (neurotic symptoms), cease to exist. In psychosis the problem is different. This is not about hampering processing of some sort of

information. The system, as a whole, became disorganized. Curiously, the mind always has a tendency to reorganization (the result of which in psychosis is the delirium) which always has to be taken advantage of. The therapeutic objective in this situation, therefore, has to be a little different from the objective classically described. Whereas the neurotic has to become aware of his conflicts, the psychotic needs to become conscious of his mental or egoic frailty and improve his capacity to "mentalize" life situations through which he went, is going through or will go through.

Unfortunately, we yet know little in relation to these processes and how to help the patients to recover (sometimes rebuild) the ability to mentalize their experiences**.** Although there is a consensus regarding dependence on significant human relationships for the development of the ability do transform facts lived through in existential experiences, little do we know how the elaboration process develops.

Authors have dedicated themselves, and those who do, to the psychological aspects linked to the learning process – acquisition of cognitive elements of reality – state that also learning depends on significant relationships. If, as lecturers and psychoanalysts affirm, affective processes are fundamental for learning and mental developments as a whole, the importance of the cognitive processes for elaboration of lived experiences became clear to me through continuous observation, not only from people who have been through episodes of mental disarray, as well as people without the necessary knowledge to resolve the situation they find themselves in.

It is a common fact to be observed. You just have to note how certain individuals behave when they find themselves in a position of supposed knowledge (a teacher in front of his students, a student undergoing an exam, a member of the Executive Power facing his superiors or representatives of the people, an analyst in front of his patient etc., etc., etc.), but not having the cognitive elements which enable them to master the situation well. By not being able to recognize their cognitive handicap, they resort to the affective process. According to each one's characteristic, some will try to leave the situation using the power of their position (authoritarianism), others will try convincing affectively (seduction) and others will try elaborating a parable which inverts the situation, as the other will have to understand and respond (delirium).

The intensity of feelings of shame, constraint, or the use of mechanisms of dissociation, refusal or rejection of the experience, are relatively common in these situations and reveal the disruptive capacity which can be the experience of gaps in the cognitive processes (5). The observation of these facts had the effect on me to permanently confirm the axiom that in the human being the absence of knowledge has been and uses to be filled with the myth (individual or group). In psychotic patients we also verify failures in the cognitive processes to be filed in by affective processes (individual mythology), but in a peculiar individual form due to the disorganization of the own Ego (6).

Maybe influenced by the important freudian concepts of rationalization and intellectualization, we ended up by deviating from the role that cognitive elements have in the elaboration processes. I believe that I am not wrong in stating that, according to Abram Eksterman, the ego is formed and consolidated not only through experiences lived in significant human relationships, but also through the acquisition of cognitive tools (information, knowledge). Applying this hypothesis to our therapeutic practice I can affirm that the Ego is not formed through interpretation of unconscious conflicts. This type of psychological intervention serves to broaden and modify the egoic structure, but does not form and consolidate it, sometimes unstabilizes same.

My experience induces me to conclude that the mental disorganization occurs basically in two situations:

1- in invasion of the conscience of the Primary Thinking Process loaded with personal and/or cultural longings in the several situations of life. The best examples are crises, which occur when adolescence starts, at the beginning of the adult age, marriage, etc.

2- in situations of major egoic demand, in which flaws in the cognitive structure become evident. In these situations, the Primary Thinking Process fill in the cracks and gaps existing in the cognitive processes in a peculiar individual form, generally fulfilling a wish of overcoming the demand to which the individual surrendered. The best examples of this situation can break out in life circumstances of changes in life, health etc., as happened when Schreber launched himself as candidate to the Reichstag.

Still in my experience, three are the existing situations which demand a bigger egoic effort regarding the elaboration (a process that involves cognition and affectivity)

a) loss of a significant relationship → by re-establishing the diadic rupture.

b) rejection within a significant relationship → by installing a mental contradiction in the mind characterised by the experience of a loss of an important relationship, although the person remais present. This is a contribuition to what García Badaracco called "maddening object" (7).

c) cultural or biological fulfilments → by unleashing enlargement and/or change in identity.

I consider these fundamental because they are related to basic elements of the biology, culture and psychological development. The inclusion of any of these experiences in the mental space will depend on the elaborating capacity of the Ego. And the inclusion of any of these three experiences in the mental space will provoke significant alterations in some of the most important systems and programs working in the mind. They have therefore the potential capacity to provoke a disorganization in one or more of these systems and programs.

How do you carry out a therapeutic task? I have some ideas. The reorganization of the Ego is made through a therapeutic dialog, which has to be a natural dialog, not stereotype or technical. To establish a therapeutic relationship it is fundamental that the patient should have an environment with a minimum of support and that the analyst should be able to create a "safe space" (8) for the patient, taking into account that only in a "safe space" the patient will be able to become aware of his mental fragility. I have observed that the omnipotent defences are the most used in the lack of this "safe space", and the interpretation of same without building the mentioned space places the patient in a mentally unbearable situation. As a reaction, this can provoke the interruption of the treatment or a hetero or auto-aggressive behaviour. The analyst plays a fundamental role in the creation of this "safe space".

The rhythm of the meetings will depend on the resources of the patient (financial means, distance, etc.) and of the analyst (available time), as well as subjective circumstances of the patient (egoic capacity still preserved: major or minor need of the auxiliary ego) and by the analyst (his ability to perform the auxiliary ego and not the auxiliary superego).

Besides, in any event we should not try to be the blank screen for the projections of the patient. Like Dante did with Virgil, we have to be his traveling companion through the hell of his mental disorganization. Once the "safe space" is built, through a real and human relationship, the analyst will be able to observe the reality and adjustment of the perceptions and thoughts of the patient, defensively veiled by hallucinations and delirium. One can start then, and only then, the delicate work of awareness the patient of the reality of his perceptions and thoughts. In my experience, the consequence of this work is the undoubtfully painful awareness of the failures of the objects of attachment (9). If, at one side, this

awareness diminishes the guilt of critics, homicidal wishes and all forms of expressions of rage and impotent resentments, it, on the other side, generates the perception of the true existential dimension of the patient. At this moment many patients interrupt the treatment.

Awareness of mental fragility is made step by step. One should not incentivate free associations, and should neither force the uprising of repressed memories nor unconscious complexes. Free associations, as well as the arising of memories and repressed complexes, correspond to the admission to the Primary Thought Process in conscience, which implies in greater demand of elaborating work for the Ego. One should not favour further admissions of the Primary Thought Process while the Ego is not strong enough to carry on the elaboration process. It is the analyst's task to manage this process, otherwise the consequence is usually a new disorganization, the deepening of the current disorganization or any negative reaction of the patient towards the analyst.

Taking advantage of opportune moments to convey information to the patient on his own mental functioning has been very useful in the egoic restructuring process. I take advantage of the actual experiences of the patients to show (present) how their psychological reactions to the environment are "protected" in their mental creations (delirium and hallucinations); how these mental creations, apparently bizarre and absurd, are shaped stemming from psychological processes of the patient himself; like past traumatic events being updated in these experiences and expressed in peculiar mental creations instead of being recognized as memories and/or like psychological scars stemming from patient's relationships.

Having pondered enough as to the use of transferential interpretations, as they tend to dissolve the transference and identification (fundamental elements for the development of the analytical process) as they render conscious these unconscious processes. Also have pondered a lot regarding facing defensive techniques used by patients. Generally speaking, I believe that defenses should be preserved.

By always being present and by having wide impact on mental process of these patients, a very important element in the treatment is the fight (pre-conscious) against the own (and frequently of the environment) stigmatization. This task usually generates secondary symptoms such as dissimulation, a certain need to show normality, denial of own psychological experiences and many others. This is an area which was studied very little, although it has a direct influence on the patient's affective and social relationships. My impression, which needs further investigation, is that the absence of the patient's effort in conquering its own (and the environment's) stigmatisation, usually represents a sign of a greater egoic deterioration.

Resuming, if psychoses are expressions of a disorganization of the mind in which affective processes occupy and fulfill lacks and cracks of cognitive processes, we should not treat psychotics through psychoanalysis trying to discover and/or reveal new or excluding psychological meanings in their mental creations (delirium and hallucinations), as, by the way, one does with hysterical symptoms. In the psychoanalytical treatment of psychotic patients, we should use their mental productions to understand failures, cracks and disaggregations in the cognitive processes, deliriously glued by affective processes. For this, the knowledge on the development of affective and cognitive processes is fundamental.

All along the psychoanalytical movement it has been extensively discussed on whom should prescribe medicaments to psychotic patients under analysis. Without wanting to stipulate a general rule on something that cannot have a general rule, my experience with this type of patient is that the answer depends on how the psychoanalyst will use medication. Knowing how to use different drugs, being aware of their different effects and side effects, using them in accordance with psychodynamic movements of the patient and not only with the productive symptomatology, does not usually slow

down the development of the psychoanalytical work. Much on the contrary, with these patients it is what generally allows the beginning of the analytical process.

One should always evaluate the advantages and disadvantages to direct the patient to another professional prescribe the drugs. If the own psychoanalyst medicates his patient, one avoids the inevitable dispute when two professionals treat the same patient. And, as we all know, this dispute fits defensive manipulations of the family, the patient or the professionals like a glove.

Another point to be considered regarding medicating a patient, and who should do it, is the frequent reaction of failure, passive or actively lived, and the loss of trust of the patient in his analyst. It is common that the psychoanalyst rationalizes these reactions of the patient attributing them to the patient (need to idealization, omnipotent necessities, etc.). Understanding it this way, the analyst ends up by using with his patients the usual communication system of their lives: once more they are used as receptacles of the insufficiencies and failures of others.

Notes:

1- To be truthful, other psychoanalysts have also studied object-relationships out of the conflict theory. A comparative survey on the different approach perspectives regarding object-relation in the psychoanalytical studies would be very interesting.

2- Term used by Balint, but never by Lacan.

3- Unfortunately this detail has been forgotten in the vast study on the so-called therapeutic negative reations.

4- There are four types of anguish: vital, existencial, neurotic and psychotic. Unfortunately, psychoanalysis has dedicated itself only to the study of neurotic anguish (separation, loss and castration experiences) and psychotic (related to experiences of disorganization of the ego, such as depersonalization, desrealization and persecution).

5- Eksterman, A. (1986) *Cognitive Gaps in the Analytical Process*, in the Scientific Bulletin of the Brazilian Society of Rio de Janeiro, R.J.

6- In my perspective, the Ego is nothing more than a virtual system wich operationalizes the functioning of the several mental systems (mnemonic, will, sensorial, identification, perceptive, cognitive, affective, etc.) and programs (of approximation of reality and environment interaction in its different relationship levels: intimate, personal and social), turning the transformation of lived facts (impulses, desires, real situations, imaginative situations, etc.) into existencial experiences possible.

7- García Badaracco (1994), p. 47.

8- From studies of animal behaviour supplied by Ethology, we know that numerous species need this space to develop and procriate. Each species constructs and maintains this space in someway. In human beings this space is psychological, built and maintained by significants relationships.

9- Cf. Bowlby, J. (1993).

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