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On the nature of intuitive and delusional thought: Its implications in clinical work with psychotic patients

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The author tries to differentiate intuitive imagination from delusional imagination and hypothesises that psychosis alters the system of intuitive thinking, which consequently cannot develop in a dynamic and selective way. Scholars of different disciplines, far removed from psychoanalysis, such as Einstein, Hadamard or Poincaré, believe that intuitive thinking works in the unconscious by means of hidden processes, which permit a creative meeting of ideas. Thanks to Bion's work, psychoanalysts have begun to understand that waking thinking is unconsciously intertwined with dream-work. The delusional construction is similar to a dreamlike sensorial production but, unlike a real dream, it remains in the waking memory and creates characters which live independently of the 'dreamer's' awareness. It is a dream that never ends. On the contrary, the real dream disappears when it has brought its communicative task to an end. In the analysis of psychotic patients it is very important to analyse the delusional imagination which dominates the personality and continuously transforms the mental state, twisting emotional truth. The delusional imagination is so deeply rooted in the patient's mental functioning that, even after systematic analysis, the delusional world, which had seemed to disappear, re-emerges under new configurations. The psychotic core remains encapsulated; it produces unsteadiness and may induce further psychotic states in the patient. The author reports some analytic material of a patient, who, after a delusional episode treated with drugs, shows a vivid psychotic functioning. Some considerations are added on the nature of the psychotic state and on the therapeutic approach used to transform the delusional structure. This paper particularly deals with the difficulty in working through the psychotic episode and in 'deconstructing' the delusional experience because of the terror connected with it. In the reported case, the analytic work changed the delusional construction into a more benign one characterised by phobic qualities. The analysis of the psychotic transference allowed the focus to be on the hidden work which had been continuously influencing the transferential picture of the analyst and the patient's psychic reality.

I began having what I don't think are dreams, since they were not like any dream I have ever had, or read of … (Philip Dick, from an interview to Ursula Le Guin, July, in **Sutin, 1989**).

Schizophrenia cannot be understood simply in terms of traumata and deprivation, no matter how grievous, inflicted by the outer world upon the helpless child. The patient himself, no matter how unwittingly, has an active part in the development and tenacious maintenance of the illness, and only by making contact with this essentially assertive energy in him can one help him to become well **(Searles, 1979)**.

Mackey: How could you, a mathematician, a man devoted to reasoning and logical demonstration … how could you have thought that extraterrestrials were sending you

messages? How could you have believed that you had been recruited by aliens to save the world? How could you?

Nash: Well, because … my ideas about supernatural beings came to me in exactly the same way as my mathematical ideas. So I took them seriously (From a conversation between George Mackey, professor at Harvard, and John Nash, Nobel laureate and distinguished mathematician, who became psychotic, in Nasar, **1998**, p. 11).

I am quoting the answer given by John Nash—whose disconcerting life has been reconstructed in the film *The beautiful mind*, not without a certain appeal, although stylistically rather sickly sweet Hollywood—in order to emphasise how the person who suffers from delusional experiences cannot distinguish between delusional imagination and intuitive imagination.

In Nash's case, his capacity for scientific intuition and his capacity for delusion were able to proceed side by side during the psychotic episode, without one interfering too greatly with the other, up to a certain point. He could be in touch with the Martians and at the same time carry out important mathematical research, but he was not able to realise the difference.

The forming of the delusional system is still a dark area for which neither psychiatry, which has studied it tenaciously, nor psychoanalysis, which perhaps approached it too cautiously, has been able to provide satisfactory answers. Indeed, we know very little about how thought and emotions are formed, the two functions that 'burn out' during delusion. The same areas and functions of our mind that make up our subjective psychic experience are probably involved in the continuous formation of the delusion which advances without limits when the dividing line between delusional and intuitive imagination fails.

This paper originates from my own personal discomfort as an analyst engaged in treating psychotic patients and explores certain aspects of the delusional formation in a patient in analysis. My clinical experience leads me to believe that, in order to understand the psychotic state, we need further knowledge about the aspects and functions of the mind, which, because of their characteristics, have escaped systematic psychoanalytic investigation up to now. Lack of this knowledge obstructs the path of the clinical psychoanalyst wanting to analyse a delusional adult.

While neurotic functioning leaves the organisation and the structure of the personality intact, the psychotic state tends to alter the unconscious functions of the perception of identity, emotions and thought. Typical phases exist as the psychotic state progresses, from the most organised to the least organised levels, in which increasing transformations of the perceptual apparatus and self-awareness are produced.

It is helpful to get used to seeing the psychotic state as a 'path', trying to distinguish the passages, phases or direction of a process that advances by degrees to reach stages of development that are irreversible and resistant to every form of therapy. When beginning therapy with a psychotic patient it is, in fact, important to gauge how far the psychotic state has advanced.[1]

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[1] In this paper, by psychotic state I mean a pathological condition that does not include manic-depressive psychosis, whose aetiology and pathogenesis have been amply illustrated by Freud and Abraham. This latter condition is characterized by free intervals during which the patient returns to his/her previous psychic functioning. On the contrary, the psychotic state accompanied by delusions and/or hallucinations is characterized by a 'defective recovery'. Split from awareness, the delusional nucleus continues to threaten the patient, albeit in an attenuated form, even during a phase of apparent reintegration.

I will now list what I consider to be the salient features in the progressive advancement of the psychotic state:

1) Psychosis is a process that, once triggered off, is by and large unstoppable. It concerns alterations of the self (the perception of continuity of individual identity), followed by disperceptual, visual or auditory phenomena (hallucinations), or by thought disorder. These phenomena are secondary to the alterations produced in the self.
2) Initial, central and final phases of the psychotic state can be described. The first phases generally coincide with pleasant mental sensations.[2] Only later do the perceptual transformations become devastating and terrifying. In the final phase, autarchic sensory production is reached.
3) In psychosis the psyche sometimes takes paths that allow it to accede to 'higher' mental states (ecstatic, telepathic) where contact with the 'divine' and the 'omnipotent' is constant.
4) Psychosis often begins with the creation of an initially benevolent and seductive object, which promises the patient a mental state of total happiness. This object is subsequently transformed from benevolent figure into terrifying object, which dictatorially dominates the patient's mind, threatening him/her if he/she dares escape its power.
5) The psychotic system is dynamically balanced with the non-psychotic part, but this relationship inexorably shifts in favour of the former.

The alterations induced in the patient's perceptive-emotive apparatus reduce his/her awareness of the process under way and completes his/her state of imprisonment more fully.

In a previous paper **(De Masi, 2000)**, I hypothesised that the psychotic state blinds the intuitive-perceptive functions of the unconscious, that is, those functions of the emotional perceptions and of intrapsychic communication that work on an unaware level.[3] The necessity to discover the areas to investigate and the task to find the adequate analytical answers, on the basis of the nature of the patient's disorder, is the common task of every analysis, but becomes particularly cogent in the psychotic patient because of the specific nature of his/her psychopathology. These introductory remarks are necessary to explain how some aspects of the psychotic state can be analysed during analytic treatment.

In this paper I will discuss a patient who came to analysis after just one psychotic episode, and whose psychotic symptoms would certainly have worsened without suitable therapy. Starting from the clinical material, I will also make some observations on the significance of the psychotic transference during the analytic process. During therapy, it is not uncommon to observe the development of a psychotic transference or of a transference psychosis, which needs to be adequately worked through and which is useful for throwing light on the psychotic functioning.

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[2] This statement may seem to contradict the observations of some authors who maintain that the initial phase of the delusional experience is always painful (for example, **Ping-Nie Pao, 1979**). In my opinion, feelings of catastrophic anxiety grip the psychotic patient only when he/she ceases to experience the sensorial self-pleasure of grandiosity and omnipotence, and becomes unable to control the transformation process of the perceptions that he/she had set in motion. For example, before being overwhelmed by the catastrophic experience of world destruction and the delusional persecution focused on Flechsig, President Schreber was caught in the sensual pleasure of transformation into a woman during sexual intercourse. If we don't admit the primitively seductive nature of the psychotic experience, it is impossible to understand the patient's attraction and 'passive' submission to it. Often, this fascinating feature of the delusional state is hidden by the patient's unwillingness to communicate it.

[3] Freud was unable to systematically investigate the unconscious functions necessary for understanding emotions and psychic reality. Nevertheless, he believed these functions to be fundamental: 'Psychoanalysis has shown us that everyone possesses in his unconscious mental activity an apparatus which enables him to interpret other people's reactions, that is,

to undo the distortions which other people have imposed on the expression of their feelings' (**1913**, p. **159**).

Intuitive imagination and delusional imagination

Psychoanalyst and analysand work in similar mental conditions to those of an intuitive scientist. The work in the analyst's room involves sensing a link between an ensemble of sense data, images, memories or emotions that had been unconnected and apparently meaningless until that moment, through operations of conscious and unconscious thought. Since the process is unconscious in the first place, it is only possible to reconstruct in retrospect the path and associative links that allowed a thought to be born. To come to life, this intuition, an inevitable and comforting widening of vision and knowledge, needs a long period of incubation.[4]

The functions of the unconscious in thought processes were identified by scholars in fields quite removed from psychoanalysis, who did not cite Freud even once nor refer to the unconscious as described by him. In studying the path that leads to an intuitive solution of a scientific problem, these scholars emphasised the unconscious matrixes of thought.

A scholar who has underlined the intuitive paths of the scientific discovery, the mathematician Hadamard **(1945)** states that the unconscious has the important characteristic of being multiple and that various and probably numerous things can simultaneously take place in it. This contrasts with the unitary, conscious ego. The discovery, says Hadamard (who follows Poincaré in this), is not due to pure chance.

The importance of unconscious thought processes in the scientific work has been also underlined by Einstein **(1949)** who affirms that it is beyond doubt that our thinking mostly proceeds without the use of signs and, furthermore, in large measure, *unconsciously*. The fact that an intuition seems to arrive unexpectedly by chance implies an unconscious process preceding it. The invention or discovery occurs through a combination of ideas: there are an extremely high number of these combinations and only a very few are useful, the majority being of no use at all. This activity occurs unconsciously and these combinations occur more readily if one's attention is kept fluctuating: to invent, it is necessary to think sideways. Naturally this recalls Freud's ‘free-floating attention’ and Bion's being ‘without memory or desire’. Creating consists in not making useless combinations and in examining only the useful ones: invention is discerning and choosing.

Poincaré **(1908)** underlines that the unconscious ego is not merely automatic; it is also capable of discerning; it has tact and subtlety. It knows how to choose; it knows how to guess better than the conscious ego because it succeeds where the other fails.

A feeling of intuitive pleasure arises when the magmatic field of phenomena and perceptions is organised around a figure that emerges from a background: this figure includes and organises all the elements present in a superior and meaningful order. This is the moment of ‘illumination’, a small or big triumph that accompanies the scientific discovery and, to a greater or lesser degree, exalts every birth of ideas.

We can therefore reach the conclusion that it becomes impossible to think if one's attention is too dispersed, while, on the other hand, forcing it too much in one direction is equally damaging to intuition.

Intuition, the insight which leads to new discoveries, enlightens us and gives an order and meaning to data that previously did not have them. The psychoanalytic

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[4] Merit must go to Freud for sensing that the flow of conscious thought must lack direction and attention must fluctuate if new ideas are to emerge: in this way he was a pioneer of modern ideas about unconscious cognitive processes. Freud's recommendation that the analyst should be like a blank screen, or Bion's take on being without memory and desire, suggests that the analytical interpretation springs from the unconscious when all mnemonic images or conscious desires are absent.

interpretation and understanding that occur in analysis are part of these 'lucky' events that happen in the specifically emotional field of psychoanalysis. But this moment of intuition is temporary because immediately afterwards the horizon widens and there is something else to be sensed or a new problem to be resolved. Consequently, man cannot experience knowledge as an attainable objective forever but rather as an open horizon that allows oscillation in creative doubting.

The point I would like to develop in this paper regards the system that changes in psychosis. This system allows intuitive thought to develop in a dynamically selective way and to carry out its function of internal communication.

A series of observations leads us to believe that the intuitive and perceptive functions of the self and of emotional awareness that allow psychic life are involved in serious disorders like the psychosis.

Fonagy and Target **(1996)** maintain that patients with serious personality disorders inhibit a particular aspect of the normal development of their mental processes—the reflective function—and so do not manage to respond flexibly and suitably to the symbolic and significant qualities of other people's behaviour and communication, as well as not being able to represent themselves and be aware of their own emotions.

I have already said **(De Masi, 2000)** that, in my opinion, the psychotic state blinds the 'unconscious emotional-intuitive functions' and so the patient totally lacks any capacity for self-observation and awareness of his/her own mental and emotional processes.[5]

I would like to differentiate here between *consciousness* and *awareness*, two concepts that are often considered equivalent. 'Consciousness' is the capacity to register a psychic event, to memorise it and to remember it. 'Awareness', instead, has to do with the meaning and understanding of that event, and is linked to the presence or absence of the intuitive function and to the capacity for self-observation.

The *state of unawareness*, deriving from the impossibility of using the unconscious intuitive function usefully, reaches an extremely high degree during the psychotic process. In the psychotic state, conditions are therefore created that contradict the analytic method itself, based on the possibility of insight by means of associative work originating from the unconscious intuitive processes.

The system that is then altered in psychosis is the one that normally allows the person to learn in a dynamically selective way from his/her intuitive experiences: consequently, the psychotic person denies his/her dependence on reality, if for dependence on reality we mean the constant doubting exploration of our intuitions.

To demonstrate how a failure in intuitive thinking makes our usual analytic work difficult, I will try to describe, and comment on, part of an analysis with A, a patient who functions in a psychotic way. In this material I will focus on the analysis of the delusional construction.

The patient in analysis

A, who is 26 years old, had a psychotic episode of a delusional nature while abroad. His symptoms were dulled by pharmacological treatment. His persecutory delusion,

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[5] Modern ideas of infant development (I am alluding to work by Emde, Stern and Infant Research, as well as to Fonagy's and Target's theories on the reflective function) highlight the importance of the child's original emotional capacities, which can be strengthened or distorted by the maternal response. It is possible these early distortions of the intuitive and emotional functions are the precursors of a person's vulnerability to the psychotic solution.

following a period of megalomanic expansion, was triggered by a quarrel with a work colleague of Iranian origin, who became head of the conspirators that were making attempts on his life. I met A after he had been in hospital and had a short period of meetings with the psychiatrist who'd had him in care.

In our first encounters, A told me he felt reassured by his return home and thought he could regain the 'affects' he had moved away from. The first months with this patient, who I saw once a week, helped me form a clearer picture of the psychotic episode and assess whether a desire to tackle an analysis might develop within him or not. Our sessions gradually increased to two a week and at a certain point he agreed to lie down on the couch. Subsequently our sessions increased to three and then four, despite his difficulty in admitting that he needed help.

However, I felt a considerable emotional coldness in the analytic relationship. I perceived that I was considered a potential intruder who should be held at bay. I also noticed that with his impersonal way of speaking the patient was slowly reproducing that suspicious, questioning atmosphere that could easily lead him back into delusion.

Although he had certainly improved and had started working again as a part-time consultant (leaving home and meeting people), he in fact functioned as though suspended between two adjacent psychic realities, one of which could unexpectedly take the other's place. He was, in fact, afraid of being poisoned in the café where he ate his lunch; he regarded the casual glance of a passer-by or a banal nose bleed as a threatening sign, proof of a conspiracy against him. When a girl who went to the same gym as he did injured herself slightly by chance, the instructor said, 'Go and disinfect yourself'. For A, this phrase confirmed that there were toxic substances in the place, used by his enemy to damage him. Although relatively improved and not openly psychotic, A felt like a threatened person, forced to live a totally clandestine existence: whenever the veil of total anonymity was violated, this produced violent persecutory anxieties in him.

At times he told me that his persecutors continued to operate by means of diabolic instruments and sophisticated devices (microphones, cameras) that filmed him or recorded his words so that he could be pointed out to whomever was responsible for killing him. I had the feeling that even the analytic room was secretly scrutinised to exclude the presence of microphones or transmitters. I soon realised that the delusional atmosphere of the psychotic episode had been re-established, recreated by the power of the imagination.

To show how the delusion is created and how its powers of attraction are developed, I will relate an episode that illustrates a sequence of this type.

While the patient was attending a conference of an organisation for defending the rights of the Third World, he joined in the ovation which accompanied the speech of a particularly vehement speaker against powerful international monopolies. He immediately felt danger in the air, concretely realised in his perception of the intentions to poison him on the part of the owner of a restaurant where he had gone to eat with his companions in the interval (he saw strange manoeuvres in the preparation of his food and the restaurant owner busy poisoning his dishes).

The patient believed that his being the object of murderous attempts depended on his joining in the enthusiasm for the speech, and thus revealing his emotions and turning himself over to the mercy of persecutors who now wanted to poison him. He was, in fact, quite convinced that when he is 'emotional' he becomes the target for terrifying retaliation.

During the session, I put forward the idea that the vehement speaker might also represent a part of himself, aggressive and polemical towards powerful organisations that

he is idealistically against. I pointed out to him that his 'emotivity' is a mental state of anger and subversive violence against people perceived as violent and tyrannical.[6]

It was clear that his improvement had taken him back into the same aggressive configuration his delusion had originated from. I believe this patient is the bearer of a conflict focusing on power (the Mafia, the clan of Iranians), capable of evoking in his imagination evil, destructive and persecutory figures. He is not, in fact, capable of differentiating between his desire to realise himself assertively and aggressive competition with a powerful person whose place he secretly wants to take.[7]

The problem posed in analysis is that of helping the patient disentangle himself from this melting pot of explosive passions, though avoiding the suggestion that he gives up his vital aggressiveness.

The psychotic transference[8]

I have already mentioned the unusual feeling of non-involvement that, for a long time, this patient transmitted to me. From the very beginning I was aware that he did not want to be involved in the relationship, even though verbal communication flowed easily between us, and that at times he was only physically present in the room. I was relieved, though, that for the whole of this period the analytic space appeared to remain a sufficiently neutral place, protected from persecution. This 'neutral' position was always on a knife-edge, however.

For example, when the patient spoke to me in this period of his doubts about leaving his parents' flat, as his mother suggested, I sensed that my eventual stance on this would be subjected to special scrutiny. If I were to express doubts about him immediately leaving home (where, among other things, the patient was more protected from persecution), it would be as though I was declaring my anxiety, confirming in some way that enemies did exist who wanted to make an attempt on his life. If I was aware of the danger, then it was also possible that I was one of them. His mother's position, pushing him out of the house, is more reassuring for him.

If a friend told him that he 'knew' where his country house was because it was near his own, then he might feel that he had been discovered by the 'organisation' persecuting him and that his friend was a spy.

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[6] On this occasion we succeeded in making some connections with previous psychotic instances that the patient had not informed me of. During a holiday break to a village in southern Italy he had felt persecuted by the Mafia. At that time, idealising himself, he had begun to think that he could defeat the Mafia. But after a while this resulted in his fear of persecution. During the ensuing psychotic crisis, he imagined being the chief of a powerful global organization that fought against injustice through out the world. However, he gradually identified himself with an avid character, ambitious and power hungry.

[7] In my opinion, this delusional constellation originates from an early infantile conflict with his father who, on the one hand, encouraged the boy's 'superiority' yet, on the other, humiliated him during their confrontations. It must be noted, though, that the patient had never been aware of this conflict: he always identified completely with his father—the 'winner'. I believe that it is this pathological identification that has interfered with the development of a separate identity and true self.

[8] Some authors (**Kernberg, 1975**; **Rosenfeld, 1978**; **De Masi, 1992**) distinguish between 'transference psychosis' and 'psychotic transference'. While transference psychosis lies in psychotic manifestations emerging exclusively in the transference, psychotic transference crosses over to include the analyst in the psychotic delusion that is developed outside the analytic relationship. Rosenfeld **(1997)** emphasises the importance of recognising quickly the development of a psychotic transference. Failure to do so can often result in the development of an acute psychotic situation. In this case, hidden and split psychotic parts escape control and overwhelm the non-psychotic elements of the patient's personality.

In analysis, if I spoke about him making connections on the basis of information that he had given me and using simple intuitions, I discovered that the patient thought I was endowed with telepathic powers and that I belonged to the organisation spying on him and wanting to eliminate him.

Once, I passed him as he was sitting in a café near my office but, as I did not see him, I did not stop and say hello. The next session, after a great deal of effort and considerable anxiety, he confessed to having seen me. It seemed to him as though I was running in the direction of a nearby small shop of Persian carpets, which was supposedly a den of persecutors who wanted him dead.

At first, I was greatly worried by this sort of communication. With hopes wavering that the analytic setting could remain free from persecution, I began to fear that I, too, was included in his delusion and would lose my analytic function.

However, I must point out that my fears did not correspond to the nature of the therapeutic process, which instead followed its course. Although worried, I thought that it would be possible to probe further, by means of the psychotic transference, into the secret scheming that engulfed and transformed the patient's psychic reality, as well as the figure of the analyst.

So I asked the patient how he thought that I, the person looking after him, could ever think of betraying him by joining forces with whomever was persecuting him.[9] He said that he knew nothing about me, that I was a stranger and that I could betray him. For example, he added, I could be frightened by his omnipotent persecutors or I might be attracted by the vast sums of money they could offer me. At this point I understood that the patient considered me to be someone so easily influenced by terror or fascinated by money that I could wipe out every affective bond that I must have had with him. A explained to me that he did not trust anyone outside his family circle.

In subsequent sessions he repeated that he did not know me, knew nothing about me. Everyone, except his parents, could be bought by enemy power or be brainwashed into destroying him. He admitted he had been reticent precisely because, not knowing anything about me, he did not trust me.

This admission of diffidence allowed me to realise better the significance of the emotional distance and feeling of non-involvement between us that I had felt right from the beginning. I could also understand his difficulty in asking me questions or finding out about me, and his apparent lack of curiosity about me. The next sessions furthered an initial working out of this point.

The patient began to think that, if he was courageous enough to find out a bit about me, he might be able to think of me as a human being and rid himself of the image suggested to him by an inner voice of me as a puppet without affections easily transformable by enemies. This acquisition could help him build a good relationship with me and could become a stable element in his internal world.[10] I understood that the construction of the psychotic transference contained, in a condensed form, the same

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[9] I asked myself afterwards why I had not interpreted to the patient in that session that I had been transformed into a persecutor on account of his projections. Evidently I had sensed that he was not able to understand or accept this type of interpretation (the description of his projective identification) because of his matter-of-fact way of thinking. For this reason I had replied in my turn with a question that I hoped might help him to reflect on the psychotic transformation that had just occurred.

[10] In my opinion, when working with psychotic or severely disturbed patients, it is necessary to keep in mind their lack of curiosity regarding the analyst as a person. In these kinds of patients, the curiosity is inhibited and is sometimes felt as a guilty, dangerous intrusion.

mechanism as the creation of the delusional system. When he felt me to be at the service of his powerful enemies, I am quite certain that the patient was projecting on to me his positions or past anxieties (his being won over by power and richness or his submission to powerful people).

I was struck, though, by his lack of empathy and his incapacity to understand the feelings of others, and mine in the analytic relationship.

In this way, it really seemed as though he could obliterate the presence of every human relationship and all positive feelings in the outside world, and automatically transform all objects other than himself into negative and dangerous ones.

Terror and imagination

Thomas Freeman **(2000)** emphasises that even when the patient has emerged from a psychotic episode, the 'crisis' continues to remain as a powerful destabilising element. Terrified of having to relive it and of becoming psychotic once again, the patient is frightened even of remembering the circumstances, let alone the evolution, of the psychotic crisis.[11] Freeman believes that this fear constitutes a difficult obstacle to overcome due to the regressive power of the analytic treatment, which tends in itself to destabilise psychic structures.

While agreeing with Freeman about patients' terror in returning to the psychotic episode, I do not believe that the hypothesis of analytic regression is helpful in explaining their difficulty to work through the 'crisis'. In my opinion, the reasons are many and are partly independent from the fact of being in analysis.

When you work analytically with a person who has suffered a psychotic breakdown you see the proof of the profound devastation the episode has left in his/her psyche. Even when it has been overcome, the psychotic episode, with all its vicissitudes, remains in the psychic world as a terrible trauma experienced alone, destined *never to be forgotten* because it is unthinkable.

The patient's state of mind regarding the past psychotic crisis, even after years, is dominated by the terror that the same delusional reality will be reproduced. Even a few words, said casually during the analytic dialogue, but which can be connected by association to the traumatic event, arouse the patient's terror, due to the unexpected and invasive feeling that he/she is not remembering the event but reliving it in the present and so is still trapped in the psychosis.

The past psychotic crisis is *like a catastrophic traumatic event*.

In this situation, every connection that leads back to the psychotic trauma is immediately abolished because, through association, it reproposes the catastrophic anxiety and rebuilds the delusion. This is why the analyst finds it extremely difficult to get to the point at which the past psychotic episode can be examined with the patient.[12]

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[11] But this is not always true. At times, the psychosis leaves such a pleasant memory of freedom and omnipotence that it is feared for its irresistible attraction. In both cases, the psychotic episode is like a minefield that appears too dangerous to clear.

[12] Terror prevents the trauma being worked through. Psychoanalytic studies on trauma tell us that the memories and feelings linked to traumatic experiences are separated from the rest of the psyche because they are unbearable. By inhibiting perception of the event, the dissociative defence prevents any working through of the trauma and perpetuates it. Recent neuroscientific discoveries have shown how panic remains enclosed in the primitive circuit of fear, referring to the amygdala, instead of following the rational circuit that includes the cortex. LeDoux **(1996)** says that the unconscious memories of fear, defined by means of the amygdala, seem to be branded on the brain.—This might be one of the reasons why traumatic delusional experiences, including delusional ones, are extremely difficult to work through.

The delusion remains like an indelibly fixed trauma that can never be 'forgotten', forever smouldering, ready to be awakened by any association, memory or allusion.

The psychotic crisis is not 'forgotten'; it does not become a memory but remains hanging imminent: for this reason it cannot be understood or worked through. To be understood and 'thought about' an event must be 'forgotten'; it must become 'past' and placed in the memory, where it can become thinkable because it is part of us but not confused with us; it must be felt as separate from the perceiving ego because it is sited in memory.

My impression is that the psychotic experience escapes this transformation and cannot be placed in the memory, as happens with the other types of experience, because of its special traumatic qualities that prevent any distancing from it and its 'being forgotten' in memory.[13] Even when the crisis has been overcome, the psychotic nucleus, neither worked through nor transformed, remains 'encysted' in the psyche in such a way as to produce instability and possible returns.[14] This seems to be one of the reasons why improvement, even spontaneous, in the psychotic state occurs through 'defective recovery', with a limited integration of personality.

Since the danger area is specific for each individual patient, my suggestion is to carefully explore the nucleus around which the delusional ideation and traumatic anxiety are organised. The strategy I chose to follow with A was to share his perceptions of terror and make connections with past and present events so that the psychotic episode could become an object for reconstruction, reflection and possible insight.

For example, as a defence against the panic anxiety emanating from the psychotic nucleus, this patient has to believe he has everything under control. Consequently, any unexpected event becomes an occasion for persecution.[15]

After two years of analysis, my impression is that the analytic work done on the reasons that led him (and lead him) towards persecutory terror has weakened the power of the psychotic nucleus to a certain extent. The past now seems relatively cleared up and it is possible to talk about it together with a view to understanding it better. In my opinion, his present anxiety has aspects that are more similar to panic or to a hypochondriac ideation, rather than to a true delusional structuring. Let me give an example.

Recently, A has had to attend a refresher course in order to find a job. This time, while no longer denying the impact that every new experience has on him, A expressed the fear that, on meeting people he did not know, his psychosis would be reproduced in the same manner as in the past.[16] In order to avoid the anxieties that would be able

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[13] Bion (**1965**, **1967**) theorises that the unconscious provides symbolic and imaginative functions which permit the transformation of sensory experiences into thoughts. Traumatic and psychotic experiences, due to the anxieties they produce, do not therefore enter the unconscious for possible transformation; consequently, they cannot be repressed or 'forgotten'.

[14] In one of her last works, Melanie Klein **(1958)** conjectured that psychotic experiences (that seem to belong to the most cruel and primitive aspects of the mind) are pushed down into such deep layers of the unconscious that any working through is quite impossible. Here they remain as dangerous, split-off entities. I believe that, in this way, with her spatial model of the unconscious, Klein was attempting to explain the problem of relapses in psychotic patients.

[15] I believe that having unexpectedly seen me outside analysis stimulated his anxiety because it dispelled the spatial separation between persecutory thought and uncontaminated analytic figure. My impression was that every unexpected event added strength to the delusional construction.

[16] During our first summer break, totally denying his anxiety, the patient had gone to a holiday club on an island in the Mediterranean, where he collapsed in a near-delusional breakdown.

to invade him too much, he imagined himself keeping away from potentially 'phobic' places, like the canteen, and bringing his own food from home so that he would not be persecuted by the idea of being poisoned. While exploring this hypothesis, he was struck by the thought that his precautions could be guessed by possible persecutors, who might then think up further ways for poisoning him. At a certain point, he said that I, his analyst, could point him out to the alleged enemies, thus rendering all his protection useless.

As I showed him how his imagination constantly develops catastrophic thoughts that expose him to panic, I also concentrated on the 'psychotic contamination' of the transference.[17] 'Why', I asked him, 'should I, your analyst, be in the service of your persecutors?' 'Because everything is possible', he replied.

Even though I was aware that my answer would collide against the omnipotent thinking he uses to construct every reality, I replied that there are possible things, improbable things and impossible things. Everything is possible only in the world of his imagination: there he can uproot every rule and have absolute freedom of imagination. A answered, 'When I came in here I looked at you and asked myself if you were good or if you were an emissary of the Iranians. Now I am really sorry to have thought that'.

The patient's 'everything is possible' announces mental chaos where everything is possible. In the imagination leading towards psychosis, multiple realities in fact exist that never contradict each other. Every new hypothesis is superimposed on the preceding one in a perceptive constellation in constant movement.[18]

The patient's persecutor can also do exactly what he wants, not only because he is persecuting him and wants to kill him (there is no limit, no representative of justice), but also because he has all the possible means, all the possible equipment, an enormously powerful apparatus. The 'everything is possible' thought reflects the exaltation of the successful delusional period. But now the prospects are overturned: before, every exalting thing was realised; now everything that A fears occurs.

The small but significant analytic sequence described above sheds light on the development of the delusional experience that leads to the creation of the psychotic transference, which can be used for beginning to understand together how the patient builds up his delusion, making me become the persecutor.

In this patient, the state of delusional terror amounts to the creation of a dehumanised world where dangerous affects such as revenge, avidity and a desire to kill are perceived as real and omnipresent, while the affective relations that link people together are quite absent: obliterated.

The persecutory development and the omnipotence with which the persecutors relentlessly harass A are credible for the patient because he himself has experienced as real the desire to dominate the world by destroying in himself every perception of bonds of solidarity and friendship.

During the same session as that related above, A successively went into, and subsequently came out of, his delusion through understanding the human relationship that exists between him and me.

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[17] In this sense, the psychotic terror is similar to the panic attack. Having suffered the attack, far from being reassured at having survived it, he becomes increasingly frightened by the original situation that gave rise to it. Having escaped from the danger only serves to strengthen the alarm. Despite A's fear of poisoning being refuted, his imagination continues to create fresh danger on every new occasion.

[18] The falsification principle and the spatial and temporal a priori are lacking in psychotic thought. For the patient, I may be the analyst, but also the person who betrays him. The persecutors are abroad, in Italy, everywhere. For these reasons, according to Popper, psychotic thinking is not falsifiable.

> I am going to try to describe the impressions of a long illness which took place quite entirely within the mysteries of my soul: I don't know why I use the word 'illness' for as far as my physical self was concerned, I never felt better. Sometimes I thought my strength and energy were doubled. I seemed to know everything, understand everything. My imagination gave me infinite delights. In recovering what men call reason, do I have to regret the loss of these joys? (Nerval, **1996**, p. 4).
>
> Here began what I shall call the overflowing of the dream into real life. From that moment on, everything took on at times a double aspect—and did so, too, without my powers of reasoning ever losing their logic or my memory blurring least details of what happened to me. Only my actions were apparently insensate, subject to what is called illusion, according to human reason? (p. 8).

With these words Gerard de Nerval announced and described in *Aurélia*, one of his most evocative works and a faithful account of his psychotic crisis, the appearance and progressive forming of the dream-delusion that would enthral him in the fascinating sway of madness.

I quote his words because I believe they describe with unusual effectiveness two aspects of the psychotic experience: the lack of awareness and the lure exerted by the psychotic world for those attracted by it. These two points ask important questions to our notice about the quality of the psychotic 'dream' and about the nature of the delusional intuition, to which I would like to add further reflections.

One of Bion's original contributions was to have put forward the idea that thought originates from forerunners and that, among these, dream-work generated in the unconscious is closely linked to waking thinking: 'The *dream-work* we know is only a small aspect of dreaming proper—dreaming proper being a continuous process belonging to the *waking* life' (**1992**, p. 19).

According to Bion, it is the *dream-work-alpha* (distinct from dream-work) that elaborates reality and gives meaning to experience by means of unconscious activity that is always active, testified to by the construction of the dream. This constant elaboration, which occurs subliminally not consciously, allows us to sense what happens inside us, to perceive the continuity of our existence and our personal identity, and to have future prospects. Waking-thought and dream-thought are therefore closely linked and mutually dependent in their working.

So that they can be used to make dreams, the perceptions of an emotional experience have to be transformed by the *alpha function* and have to acquire dream characteristics. Contrary to what happens in the psychotic state, the non-psychotic person 'makes perceptive reality a dream' and, thus, establishes the subjective experience.[19]

The capacity for understanding ourselves and the links we have with objects derive from the continuity and reciprocal permeability of waking-thought and dream-thought. But the way by which we know ourselves and become aware of our psychic reality escapes our conscious perception.

I would like to refer here to the contribution of another particularly intuitive psychoanalyst, Bollas (**1987**, **1992**), who speaks of the 'unthought known'. With this

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[19] In this sense, the capacity to 'dream' is fundamental for the development of the imaginative function that allows perception of one's own emotions and those of others. Bion calls this function 'reverie', that is, the spontaneous capacity to use the intuitive imagination in order to understand the emotions.

'unthought known', Bollas alludes to the connection that escapes representation, an unconscious dream that works in everyone's being and expresses the need to recognise the part of the psyche that lives in a world without words.

In other words, we do not recognise certain areas and functions of our mind that contribute to the formation of the subjective experience. This is the area that both realistic and delusional intuition draw from. A mysterious watershed line separates the two attitudes: *dreaming in order to intuit* or *dreaming in order to enter into delusion*.

Apropos of the use of visual images in dreams, Chianese writes,

> What distinguishes dreams from other formations of the unconscious is the visual element, which has a singular constitution. What is seen in dreams cannot be confused with what is seen in the waking state. The visual element in a dream is both near and far, intense and evasive, within reach yet untouchable. The image is never a simple copy or reproduction of reality; it combines figures far apart in time and space. The visible in a dream is close to the invisible that an artist renders 'visible'(**2000**, p. 326).

In 'dream-thought' (dreaming for intuiting), the dream corresponds to a symbolic transcription of an emotional experience and the images of the dream refer to the thoughts of a language that tries to integrate the dreamer's emotional story, defences or unconscious fantasies.

In 'dream-delusion' the visual element does not refer to the invisible made visible by the artist or to the invisible that the intuitive function of the analyst and the analysand would allow to be understood and revealed. The psychotic state, instead, announced in the dream, confers a concretely hallucinatory character to the dream, allows no room for intuition (insight) and interferes with the dream-thought function. In 'dream-delusion' (as in hallucinations) the visual perception annihilates the intuitive imagination and takes the place of representation.

In our analysis with psychotic patients, we must be careful to distinguish 'dream-thought', the expression of the normal function of dreams, from 'dream-delusion', which alerts us of the way the patient's perceptive experience is being transformed and which will lead him/her to clinically evident psychosis **(Capozzi and De Masi, 2001)**.

Bion would say that the psychotic individual cannot talk to us of the difference between dreaming and waking, between the dream and the non-dream, and that we, in turn, cannot distinguish between his/her dreaming and his/her sleeping (Grotstein, personal communication 2001).

While resembling a sensory production similar to the dream, the 'dream-delusion' remains fixed in the waking memory and, in the waking state, continues to give life to its characters that impose themselves on the 'dreamer'.

I will describe a fragment from the supervision of a young patient in analysis, whom I will call B, in order to show how the power of the delusional imagination is constantly at work during the psychotic process: '*A thought came to me yesterday evening when I was half-awake, a fantasy perhaps, but I don't know to what extent it was ... I remember that after I had begun analysis with you I came here one day when you were not working but just seeing various people. You arrived shortly afterwards and were surprised to find the door open: you asked yourself if you had left it open by mistake or if someone else had come in. I thought it might have been children looking for documents: you asked me to go and have a look and ... I thought perhaps there was a room at the end in a terrible mess but I didn't/hadn't even realised ... I thought I might have seen two young boys escaping*

as I came in, but I hadn't paid any attention and would not be able to recognise them ... I felt totally useless, as though you had asked me for help and I had not been up to it ...'

B has been in analysis for two years at four sessions a week for a previous delusional episode. The patient's psychotic episode was focused on persecution by criminals who had threatened him in a discotheque and on the repeated perception that he had killed someone in a car without realising.[20]

I will not dwell on the significance of the patient's delusional fantasy, the emergence of the figure of a parent–analyst as a mother incapable of defending herself and who asks him for heroic performance, or his world populated with bad people, young delinquents from infancy now wrongdoers to be feared, all important elements in the delusional construction and taken up in the analyst's interpretation. Instead, let us listen to the patient's comment after the analyst's intervention, who can only remember having received him on a half-holiday and who believes that the subsequent sequence of events was constructed by the patient: 'I realise that before I had real things under my nose that I did not see, while other things that I invented seemed real … Now I am less obsessed with the idea of having caused crashes, I am pretty much convinced that these were fantasies, but I still keep on creating others …'

In other words, B is beginning to realise that his imagination is ceaselessly at work falsifying the memory of events and that this happens quite out of his conscious control.

Something paradoxical happens in delusions compared to dreams: while dreams are mysterious since their significance awaits discovery, delusions are frightening since their significance is manifest. They are 'dreams' that never end, unlike real dreams that disappear when their communicative function is over. Delusion constantly searches for confirmation in order to maintain its whole assertive force intact.

For example, if I try and show patient A how his persecution might have originated from megalomania, and hypothesise that he was perhaps unable to accept that he was of no importance to his Iranian colleague (who destroyed his megalomanic sense of existing by stealing his girlfriend) and that, to defend himself from this humiliating perception, he has fantasised an epic struggle without end against his rival, the patient says that he understands this hypothesis of mine, which goes in one ear, and finds it useful. However, as soon as he leaves the session, it comes out of the other and he forgets all about it.

In other words, the delusional memory is not liable to working through until the patient can remove himself from the highly imaginative power of his grandiose self and his true personal identity is sufficiently developed.

In the therapy of these patients, it is important to understand the strength of attraction and the power of the delusional imagination, by identifying the underlying anxieties or omnipotent desires stimulating it, and to try to 'deconstruct' it.

I use the term 'deconstruction' because the word 'interpretation', which we use for indicating our therapeutic tool, does not seem suitable for the clinical problems posed by the power of the delusional imagination.

Thus, I would like to emphasise the fact that the analysand and analyst must be able to examine and recognise gradually and in detail how the delusional experience is built up and how it develops, by accurately examining the emotional conditions and the delusion's far-off preparatory roots, and linking up the various scattered fragments,

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[20] The patient, who had never thought of asking for police protection against his persecutors, was delusionally convinced of being guilty, therefore wanting to give himself up and be charged.

which have appeared and continue to emerge during the analysis. This work must be done constantly, session by session, over a long time.

In my case, I gradually realised how important it was to return to the first delusional episode that had signalled the start of the patient's psychotic state and to try and hold this reference point stable for a possible working through of the delusion.[21] In fact, only by containing the energy of the delusional fantasy and constantly seeking its reasons in the present and in the past can mental spaces be usefully liberated for a possible development of thought and personal identity.

A special aspect of our analytic work dealt with reconstructing A's infancy. My opinion was that a delusional idealisation of his father and an omnipotent identification with him was an essential factor in his delusional construction, which had his roots in his childhood. As a child, A admired his father and wanted to be like him. Just as his father imposed his supremacy over his mother or over the patient himself, so A continually demanded acts of submission from his younger sister. He was fascinated by games of skill and was fanatical about records, with which he often claimed exceptional confirmation from his mother, who, in the patient's memory, watched him with ecstatic admiration. The game of being like his father was not a 'game' for the patient but reality (he *was* his father), a pathological and omnipotent identification with a grandiose figure. In adolescence, he was so entrapped in fantasies in which he performed heroic deeds that his companions had to bring him back to earth to get him to re-emerge from his exciting withdrawal.

My clinical experience in this case was that the 'deconstruction', or the dismantling of the delusion's construction of the patient, allowed the acquisition of the functions of awareness that gradually permitted A to begin to 'see'.

Maintaining this capacity over time guarantees that the delusional experience, where it reappears, is recognised and made potentially transformable, thus preventing its automatic conquest of the mind.[22]

As an example of this possible passage, I will relate A's analytic experience when we were trying to understand better the dynamics of the passage from the state of grandiosity to the persecutory delusion. On this occasion, the patient sensed that he had projected his own omnipotent mental state into the Iranian colleague, when he did not refrain from courting the girl and finally seduced her. In his mind, the colleague became his persecutor who wanted to take revenge upon him because A had dared to bar the way to his omnipotent power. I think that the clash with his Iranian colleague was so catastrophic because it had killed not only the patient's omnipotent self, but also his potential self connected with it. The projected grandiose self was now perceived as threatening and capable of doing what it wanted with him.

In reality, the competitive aspects of his colleague had served the patient as a means for making this person a suitable object for the projection of his own omnipotent, avid parts that were full of a desire for domination and narcissistic triumph. In this way, the mad part of the patient, sited in his colleague, had begun to live an independent life that was, though, indissolubly bound to him as the effect of an omnipotent projective identification in the sense described by Klein **(1946)**.

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21 An important point that must be considered is the significance of the very first episode. It is not only the stirring outbreak but also a dynamic fact of enormous importance, without which the patient would have been able to stop, or even compensate, his disposition to the psychosis' (Arieti, **1974**, p. 909).

22 Similar considerations, although less dynamically complex, must be made regarding the construction of perverse systems, panic attacks or hypochondriac states.

I have described this passage because it seems to me to represent one of the moments that initiated the 'deconstruction' of A's delusional experience. Through this process, the delusion ceased to be a concrete mental state imprisoning the patient and became a psychic fact in which the delusional experience began to be 'digested' and transformed since the patient himself became able to think about and understand his contribution to the delusional construction.

This analytical material has become more and more frequent in A's analysis as the patient has strengthened his intuitive thinking, which was almost absent in the beginning of this therapy.[23]

Conclusions

I have expounded part of the material of a patient's analytic treatment in order to show the difficulties that are encountered in analysis when intuitive thought gives way to the development of delusional thought. I have also pointed out the need to relive with the patient the psychotic episode, which can return and make its presence felt even during the analysis, in order to work through it bit by bit as intuitive thought develops. This operation is anything but easy on account of the traumatic anxiety, which tends to keep the psychotic episode split from awareness and is therefore a potential generator of further psychotic crises.

The 'assertive energy' **(Searles, 1979)** that sustains this patient's psychosis seems to lie in the development of an ideational system where the grandiose imagination has taken the place of the ordinary capacity to evaluate his own, and other people's, mental processes. From this point of view, we can understand A's grandiose evolution as a defence against the anxiety of annihilation ('being nothing'), an illusional defence that further destroys every possible recovery of personal identity.

If, in order to exist, the psychotic person has to transform his/her identity by altering his/her perceptive functions, he/she will contemporaneously annul the system of emotional truth (the emotive-intuitive unconscious) that allows him to grow mentally and to understand emotional reality. For this reason, he/she is destined to plunge into chaos.

The unceasing role of the solitary imagination, which is like a film projected in the mind with characters living their own lives, becomes all-important in the psychotic system. Projected in the mind, this film blocks the channels of the patient's intuitive imagination and exerts a powerful attraction over him/her.

The theoretical references peculiar to psychoanalysis for understanding the delusional construction, such as projective identification, omnipotent unconscious fantasy or the hallucinatory realisation of desire, although working in the psychotic state, do not seem to be sufficient for understanding a complex transformative process that tends to be unstoppable and constantly changing, like that sustained by the delusional imagination.

I believe, therefore, that we must contextualise the statute and role of the delusional imagination better, in order to distinguish it from other forms of imagination such as day-dreaming,

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[23] In working with psychotic patients, the analyst must be alert to the moments when, through dreams or particular associations, the intuitive imagination, or the capacity to understand one's own mental processes, begins to manifest itself.

withdrawing into fantasy worlds and childish games, up to religious or artistic imagination, in which the defensive, explorative or constructive aspect appears evident.[24]

In other words, what are the positive imaginations necessary for keeping the future open or for building new shared realities ('dream-thought') and what, on the other hand, are the falsifications of a delusional nature ('dream-delusion')?

Though produced by the imagination, delusion is a construction at odds with the development of thought.

The paradoxical element is that thought, like delusion, is sustained by the imaginative capacity; it originates and is maintained by this.[25] In order to think, one must be able to imagine. The imagination or the capacity to dream, which are the means allowing the birth of thought, must never be extinguished if we want psychic life to remain as a potential space open to the future.[26]

A characteristic of the psychotic state is not so much projection towards the world or indeed curiosity—qualities peculiar to intuitive imagination—but a psychic retreat and a use of the perceptive organs to build an artificial sensory state of mind.

The constant production of newly created realities, projected outside him/herself, means that the psychotic person reaches the mental state attributed by man to God, who created the world out of nothing as a projection of his own imagination.

To assert itself, delusional reality must, therefore, annul the hypothetical or explorative nature of thought, removing every metaphorical value from it.[27]

Arising from a specific intention to transform psychic reality, delusion blocks the potential space for thought and, while being produced in individual fantasy, kills the intuitive imagination and takes its place. The delusion is like a fetish, a closed system that engulfs the infinite potential of thought.[28]

An equally important issue is how to handle the transference (and what should be intended by psychotic transference), which, in the case of psychotic patients, is certainly not a revival of past conflicts. Personally, I believe that the profound alterations of the perceptive function in the psychotic state prevent the neurotic transference being likened to that of the psychotic state.

The importance of the transference analysis, which constitutes the basic element of the analytic technique, in fact, derives from a genetic hypothesis of the mental disorder. Simplifying this greatly, one might refer to the Freudian model hypothesises that, during the childhood, an idea or an instinctual complex is subjected to repression since it is a generator of a conflict. In parallel, the Kleinian model proposes that parts of the

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[24] This topic has been thoroughly debated in the Internet discussion, co-ordinated by Paul Williams **(1998)**, of 'Psychopathology and primitive mental states' by Robert Caper **(1998)**. The discussion highlights how difficult it is to theoretically classify delusional thinking.

[25] As Freud **(1911)** set out in 'Formulations on the two principles of mental functioning', the pleasure principle, which pre-exists the reality principle, continues to work even after the latter asserts itself. Fantasies and dreams are expressions of the pleasure principle that form a thought activity parallel to the one inspired by the reality principle.

[26] Through his imagination the child is able to create, but in his play he is aware of exploring new realities. Imagination permits him to discover an as yet experienced reality; a reality lived by the others. 'Pretending to be' is the area of the fantasy necessary for psychic development and for the identification with parents. In his childhood games, A did not pretend to be the father, he was the father. Even religion belongs to the realm of imagination, creating a shared imaginative area, a psychic reality, in which it is possible to believe.

[27] Artistic creations fill the potential possibilities of the imagination, creating new imaginative worlds and broadening psychic reality. For this reason, these new worlds

become new shared realities, potentially usable by all. On the contrary, the perverse imagination creates a fetishist world with fixed, psychotic-like qualities, in which the potential space is destroyed.

28 Melanie Klein **(1930)** states that the psychotic patient is imprisoned in his madness by the power of his sadistic cruelty, experienced as a terrifying, persecutory presence. Consequently, the capacity of symbolic thinking is lost, resulting in an arrest of the psychic development.

personality are split off and projected into the analyst who becomes the container of the patient's unwanted and unconscious parts.

The transference, therefore, is the indicator of the permanence of the conflict or of the action of an unconscious pathological fantasy. It is possible to work through the conflict or integrate the split-off part of personality only through analysis of the transference.

From this point of view, the psychotic transference does not have much in common with transference as a revival of the past or as projections of unconscious parts of the self; the psychotic transference has its own specific character linked to the nature of the psychotic state. I believe that Freud, who thought of transference as a revival of the past, meant this when he maintained that psychotic patients are incapable of forming a transference.

My impression is that childhood conflicts certainly exist but, not having been mentalised due to the precocity of the traumatic experience and the absence of unconscious intuitive thought, they are not part of the transference formation as normally happens.

In this work I have considered the psychotic transference as a ‘psychotic contamination of the analytic relationship’, a new creation of the constant omnipotent imaginative activity that transforms the figure of the analyst in the same way as the patient's psychic reality and that must be adequately analysed and made explicit.

This paper, which attempts to examine in greater depth an aspect of the analytic encounter with psychosis, stems from my overall experience in the treatment of this type of patient, going beyond the cases described above. I have endeavoured to point out some constants that must guide our therapeutic approach and help us to have a specific mental setting during the analysis of a psychotic state.

I am profoundly convinced that the more we introduce psychotic patients to our analytical rooms, the more elements we will have to further our knowledge about this mental condition and the ways to make it liable for working through.

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