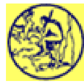 The International Journal of Psychoanalysis

(2010). International Journal of Psycho-Analysis, 91(6):1337-1361

Psychoanalytic Theory and Technique

Mourning and Psychosis: A Psychoanalytic Perspective[1] [Duelo y psicosis: Una perspectiva psicoanalitica]

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(Final version accepted 2 November 2009)

The author attempts to develop some of the basic models and concepts relating to mourning processes in psychotic patients on the assumption that situations of loss and mourning are key moments for psychoanalysis, psychotherapy, and therapeutic approaches in general. Secondly, he reminds us that 'mourning processes in psychotics' are not always 'psychotic mourning processes', that is to say, that they do not necessarily occur within, or give rise to, a psychotic clinical picture. These ideas are illustrated by a number of sessions and vignettes concerning two psychotic patients in psychotherapeutic and psychoanalytic treatment. In theoretical terms, it seems vitally important in this context to combine a relationship-based approach within a framework of special psychoanalytic psychopathology with an updated view of processes of mourning and affective loss. A fundamental requirement at clinical level is to determine the role to be played by psychoanalytically based treatments in combined, integrated or global therapies when working with psychotic patients. For this purpose, the paper ends by outlining a set of principles and objectives for such treatments.

Introduction

Psychotic patients, including those we call 'schizophrenics', are obviously affected by mourning. Clearly, too, understanding and help in these mourning situations seem to be more difficult, or are at least neglected by contemporary psychiatry, psychotherapy and even psychoanalysis. However, a number of different starting points, whether psychological, psychopathological, theoretical or clinical, can be adopted for the study and definition of the characteristics of 'psychotic mourning'. For example, some of us believe that there is great clinical advantage in combining a *special psychoanalytic psychopathology based on relationship* (**Liberman, 1978**; **Simonsen, 2008**; **Tizón, 2004b**) with psychoanalytic models and concepts applicable to the processes of working through and mourning.

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[1] Translated by Philip Slotkin MA Cantab. MITI.

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In the past I defined 'psychotic mourning' as a mourning process taking place principally in the paranoid-schizoid position, probably as a defence against the most primitive confusional anxieties of integration/disintegration. To define the concept rather more strictly, I now consider it preferable to use the term *psychotic mourning* to denote a type of mourning which aggravates or re-initiates the psychotic clinical picture, or which triggers a clinical psychotic episode. I distinguish this from *mourning experienced in the paranoid—schizoid position*, in which the mourning processes are *psychodynamically psychotic*, and may or may not give rise to a psychotic clinical picture; however, the associated fundamental anxieties and defences are those already described by Melanie Klein as 'psychotic' — i.e. those belonging to the paranoid—schizoid position **(Klein, 1946)**, sometimes accompanied by 'primitive confusional' anxieties, which are even earlier than those mentioned, but which always lie at the root of psychotic crises. Psychotic mourning (and 'psychotic elaborative processes') usually occur in persons with psychotic structuring/destructuring of the personality, as well as in subjects with, and during phases involving, significant faults and unbalances of psychological structure, i.e. so-called borderline (between neurotic and psychotic) patients or processes. Nevertheless, *psychodynamically psychotic elaborative processes* or *such processes experienced principally in the paranoid—schizoid position* may occur in any of us depending on the particular variables and circumstances of the loss concerned.

I have attempted in previous contributions (Tizón, **2004a**, **2007b**) to outline, update and organize our current concepts of mourning and mourning processes, bringing together both the various psychoanalytic perspectives and bio-psycho-social approaches. In sum, it is in my view appropriate to simplify our conceptualization by distinguishing *normal, complicated* and *pathological mourning processes*, each of which should correspond to a level of social aid which I have attempted to spell out, with the aim of protecting the mourning subject from unforeseen and unnecessary interventions. When faced with mourning processes, we should perhaps always consider first whether the action required of us is to *accompany, to advise* or *to intervene* (on the appropriate specialized level). I have also attempted a classification in groups of the moments or phases of each mourning process and of the motivational, affective and cognitive tasks which confront us in these situations **(Tizón, 2004a)**. In this paper I wish to develop some of these basic ideas in connection with the specific case of mourning processes in psychotic patients, and, in particular, my current view that mourning situations are key moments for psychoanalysis, psychotherapy and therapeutic approaches in general when working with patients suffering from a psychosis.

Secondly, I should like to remind the reader that mourning processes in psychotics are not always psychotic mourning processes — that is to say, ones experienced in the paranoid —schizoid position. In so doing, I am merely developing and stressing a requirement incumbent on any psychotherapist working in the context of a combined therapy with a psychotic patient — namely, that he[2]

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[2] Translator's note: For convenience, the masculine form is used for both sexes throughout this translation.

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should consider these events and phenomena as tantamount to a 'royal road' to the understanding of these patients and to helping them therapeutically. Freud many times described dreams as the 'royal road to the unconscious'. Similarly, I believe that mourning processes, considered from the post-Kleinian point of view as processes triggered by loss, frustration, or chronic pain (Klein, 1935, 1940, 1945, 1946), are 'royal roads for the manifestation of various organizations of relationship', and, among these organizations, its fundamental nucleus, the object relationship — especially in severely ill patients. That is the third point I should like to make in this paper: that mourning processes tend to bring to light the patient's principal organizations of the relationship, in the sense of the term that I use in the context of special psychopathology (Tizón, 2006, 2007b). The problem is that the self of a psychotic patient is always poorly integrated (Cullberg, 2006; Fonagy et al., 2002; Freixas, 1997; Frith, 2005; Laing, 1960; Rosenfeld H, 1952, 1965), and so too are the various organizations for relationship, so that they are often difficult to apprehend and hence to interpret. This is because, fourthly, mourning processes in a psychotic patient can in my view be dominated by the psychotic part of the personality — that is, by the combination of the unintegrated, defective parts and the symbiotic—adhesive relationship as a defence — or else they may be dominated by 'healthier' parts or aspects (Cullberg, 2006; De Masi, 2006; Laing, 1960; Rosenfeld H, 1965). From this point of view, mourning processes, even in psychotic patients, can basically be experienced with other organizations of relationship — hysterical, avoidance-directed, obsessive-controlling, non-containing by means of action, paranoid, etc. — as described by Liberman (1978) and myself (Tizón, 2003b, 2004a, 2007b). For this reason, mourning processes in psychotics may sometimes appear crystal-clear and on other occasions utterly obscure, disjointed or dissociated. Again, the dominance of one or other form of organization for relationship will crucially determine the technique we must apply to assist the mourning process. However, it must be borne in mind that, when I use the phrase 'royal roads to the manifestation of the various organizations for relationship', this also entails appropriate techniques for addressing them. After all, the situation in the therapeutic relationship differs according to whether the patient is dominated (a) by the 'psychotic part of the personality' (Bion, 1957, 1967; De Masi, 2006; Rosenfeld H, 1952, 1965; Meltzer, 1986; Meltzer et al., 1975; Tizón, 2003b, 2006), which signifies disorganization, dis-integration, and perhaps defective aspects, or (b) other aspects or forms of relationship, in which case we must deal with actual conflicts in the more classically psychoanalytic sense of the term, starting with those characterized by deep and almost inexhaustible ambivalences — but also including other types of conflicts, whether with a more paranoid type of organization or even ones that are more 'neurotic' (Meltzer et al., 1975; Tizón, 2003b, 2006).

Fifthly, I suggest attempting to combine the chronological model of the development of mourning processes with the dynamic characteristics of the process as a whole and of each of its fundamental phases (Tizón, 2007b). By understanding the process in this way, we may perhaps be able to help the patient to work through it on a 'reparative', or at least 'paranoid—schizoid', level, and to avoid or reduce its infiltration by confusional anxieties and those of differentiation/non-differentiation.

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In sum, I should like to draw the attention of psychoanalytically oriented therapists to the important role that can be played by their participation in the treatment of psychotic patients. This is of course a highly controversial issue both within and outside contemporary psychoanalysis (Grotstein, 1985; Lucas, 2003; MacKinnon and Michels, 1971; Michels, 2003). However, I am convinced of the value of psychoanalytic contributions in this field, especially where loss and mourning are concerned, as well as in teaching us to focus on mourning experienced in the paranoid—schizoid position when working with other patients — specifically, those falling more into the category of 'borderlines' or 'neurotics'.

In psychotic organizations, the task of *forgetting by remembering* that must be performed in any mourning process may prove to be drastically altered in its dynamic and evolution, with consequent changes in the re-hierarchization of the internal world, real or symbolic reparation, and the recomposition of that internal world. On account of psychotic defences and, in particular, the aspects of certain losses which cannot be worked through, unconscious phantasies of distrust are reactivated. In the absence of help with this process of working through, the paranoid nuclei and anxieties (or the defences of 'incoherent narcissism' against them) will be reinforced. In the most common situation, the fragmented *psychotic self* cannot make adequate use of the effects of the mourning processes to encourage the creativity and development of the personality as a whole (Fonagy et al., 2002; Laing, 1960; Tizón, 2006; Volkan, 1995). One reason for this is that these effects are less well perceived and processed so that, in consequence, their mutative capacity on the patients of these patients' personality and internal world is reduced, especially as their difficulties in the cognitive processing and recomposition of external and internal relations tend to become chronic — at the psychological, neurological, and social levels (Cullberg, 2006; Frith, 2005; Gabbard, 1994; Weinberger, 1987; Zubin et al., 1992). As a result, severe, repeated situations of mourning may impair the progress of a severely ill psychotic patient, a schizophrenic, or a child with a multi-systemic developmental disorder — in particular, owing to the increase in intensity, within the personality as a whole, of phantasies and experiences of distrust and of the most primitive, most 'psychotic' defences.

Furthermore, the overall situation differs substantially according to the specific phase in the development of the pre-psychosis and psychosis at which the various stages of the mourning and/or working-through processes take place. I am referring here not only to the initial instant of loss, but also to the various subsequent moments in the development of the mourning process, which may, by virtue of their duration, be superimposed on particular phases in the development of the psychosis (Cullberg, 2006; Edwards and McGorry, 2002; Freeman, 1969; Johannessen et al., 2006). Since I cannot consider this combination of chronological variables in depth here, I invite the reader to reflect on it himself. This can be done on the basis of the ideas of, say, Volkan (1995), Alanen et al. (2000), Jackson (2001) or Cullberg (2006), as well as of the theoretical aspects discussed above or in my book on the subject (Tizón, 2007b) — not, of course, forgetting the new relational perspectives of recent empirical studies of incipient psychosis (Edwards and McGorry, 2002; Read et al., 2004, 2008; Yung et al., 2004).

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Based partly on **Alanen (1997)** and partly on recent empirical research on early treatment of the psychoses, **Cullberg (2006)** describes the following phases in the development of a psychosis: prodromal; pre-psychosis; psychosis (initial phase); psychosis (late phase); and post-psychosis. As an introduction to my proposed descriptive analysis, let us consider what may happen at the psychological level when a patient is in the situation of pre-psychosis, *trema*, or period of 'incipient psychosis': the outside world seems to him to be altered and threatening, other people are making fun of or talking maliciously about him, there are echoes and interferences in his thought, as well as a sensation of imminent catastrophe which raises the pitch of persecutory anxiety, while disintegration anxieties have at the same time been unleashed. This results in serious alterations in the patient's nychthemeral rhythm, in caring for himself, and in attending to his basic needs, as well as a risk of suicide. Now imagine what may happen if an affective loss, accompanied by mourning, occurs at the same time, due, for example, to the break-up of a relationship (a frequent occurrence, at least in young girls who have managed to establish a relationship). The world then becomes even more difficult to interpret, more confused or more openly persecutory, and this is one more reason for the patient to isolate himself and avoid being made fun of. Guilt and self-accusation may be embodied in persecutory, reprimanding voices, or may intensify such voices if they already exist. Moreover, all this may be followed by autistic withdrawal and forms of behaviour tantamount to 'entrenchment' (with the aim of avoiding these external and internal persecutions), increased difficulty in processing information at external and internal level, even less attention to the satisfaction of basic needs, and an intensification of suicidal ideas, whether for reparative or paranoid—schizoid reasons, and so on.

Two Illustrative Vignettes

In this second part of my paper, I shall attempt to illustrate the two types of mourning processes in patients in psychoanalytic treatment or psychoanalytic psychotherapy. I shall also use these examples to make some additional comments on the other aspects of the psychoanalytic psychopathology of mourning just mentioned. However, I cannot of course illustrate all the aspects enumerated, even in outline, as this would extend beyond the bounds of the sessions reported and of my descriptions and interventions, or else add enormously to the length of this contribution. For this reason, the extracts from sessions presented and my comments on them will focus on the central theme of my paper (the two types of mourning processes), at the expense of wider or more general remarks or analyses. The aim is to illustrate the variability of mourning processes in psychotic patients and the importance for therapists of taking these into account and of helping the patient to work through them.

The Proud Artist

I shall begin by attempting to illustrate a psychotic mourning process (that is, one experienced in the paranoid—schizoid position, which develops into a

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psychotic clinical picture) in a female patient in psychoanalysis. Let us provisionally call her the ‘proud artist’, or Daphne.

Daphne had just turned 20 when she began her analysis. Owing to difficulties with accommodation and residence, session frequency varied from three to five times per week, although greater continuity in the therapy would have been desirable. She is the daughter of a severely melancholic mother who had made a number of suicide attempts and been through phases of deep depression, with the status of an invalid on account of her psychiatric disorder. One of her depressive phases coincided with the birth of Daphne. She had in fact been undergoing treatment with antidepressants for almost two decades, which, as we are now beginning to realize, eliminates the ‘depressive’ affects from her communication, but not from her relating, so that her relationship with her daughter becomes a paradigm of ‘anxious attachment’, albeit without many of the associated emotional components. All the same, when they are together, intense and continuous conflicts break out, possibly exacerbated by the mother's guilt and by occasional manic reactions in both women. As is often the case, Daphne's first overtly psychotic symptoms appeared at the time of the process of separation—individuation in puberty and pre-adolescence, revealing that there had already been problems of primitive triangulation. Unable to work through the many different processes of mourning and change involved in this situation, she reacted with her ‘non-psychotic’ part, dominated by ‘non-containment through action’, emigrating over a distance of more than 600 miles to Barcelona, where she knows hardly anyone.

Daphne is a very gifted person on the cognitive, symbolic and cultural levels. While not beautiful, she is in general attractive, her appearance being impaired only by a constant rictus or haughty grimace in her face and by various physical mannerisms. One's attention is attracted from the beginning not only by this grimace of pride, but also by a whole set of defensive manoeuvres presented as pride and a need for distance, but which I soon recognized — to her annoyance — as mere contrivances to defend against the confusion and intense persecutory anxieties triggered in her by the slightest intimacy of relationship. From this point of view, she had difficulty in accepting the analytic setting, owing both to the closeness of the relationship involved and to the use of the couch, but was able to accept the latter. Moreover, she did so from the beginning, although not without protest.

In accordance with my recommendation in such cases (**Alanen et al., 2000**; Tizón, **2004b**, **2007a**, **2007b**), I arranged a ‘combined therapy’ setting which I agreed with the patient and, by telephone, with her mother. The treatment as a whole was to comprise: (1) psychoanalysis; (2) visits to a psychiatrist directly recommended by myself, with whom I collaborate specifically in these situations (although in this case, I must say, his diagnosis did not at first coincide with mine); (3) family interviews with the psychiatrist, which were necessarily infrequent because the parents lived so far away -and almost always only with the mother, who accompanied Daphne to the monthly psychiatric sessions if she was in Barcelona; (4) the medication prescribed by the psychiatrist, which for several months comprised antidepressants, and later ‘atypical’ neuroleptics; and (5) Daphne's agreement, which

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was very painful to her, that she would accept the psychiatrist's recommendation of a brief period of hospitalization if necessary.

When I met Daphne's father, on one of the occasions when I had to alter the setting owing to one of her psychotic decompensations, not diagnosed in time by the psychiatrist, I found myself face to face with a person not only on the defensive but also seemingly ‘entrenched’. My perception of him, furthermore, was as someone totally overwhelmed by the invasive, interventionist mother. Particularly conspicuous features were a generalized dermatitis, which extended to his face, and the impression he conveyed in the interview, where he proved virtually inarticulate, experiencing severe emotional and language-related problems, which even suggested to me that he himself might have suffered in the past from a psychosis, from which he had perhaps recovered with certain scar-like defects, or possibly with a severe phobic avoidance. I was of course unable to diagnose either this or the nature of the relationship, because I saw him only on this one occasion, apart from fleetingly at intervals in the waiting room.

A session from mid-October

The fragments of sessions presented below date from the days following Daphne's conflict with Pablo, her new ‘boyfriend’, the details of which it is appropriate to record. At this time, Daphne had already suffered at least two acute psychotic episodes, both of which she had managed to ‘resolve’ with her substantial cognitive capacity and her social relationships, albeit not without acting out, serious dangers, and a degree of social impairment. As she herself told me, the first episode had to do with her initial attempts to form relationships, in a very confused environment, in the town where she grew up, involving occasional drug use, as she approached the age of 17. She ultimately had what was probably an acute paranoid delusion that needed psychiatric assistance and that was seemingly resolved within a period of weeks or months — but not without serious instances of acting out: Daphne decided that she could no longer see any of her friends, virtually ceased to go out into the street for months on end, and finally persuaded her parents to allow her to commence her studies … 2000 miles away! However, she did succeed in finishing two courses. Her subsequent time in Barcelona was as stormy as might be expected, although, with the help of the psychoanalytically based combined therapy, she was able to finish her studies in one of the city's most demanding faculties, and her teachers themselves provided her with recognition, grants and the first artistic assignments that provided her with the wherewithal to live on.

She then reverted to her old ways. Having appreciably improved, she embarked on postgraduate studies and practicals in her subject, for which purpose she had to work in a group. Without telling me this at any time, she embarked on an erotic relationship with a member of the practical group, more than ten years older than herself, whom she describes as an ostentatiously peculiar and egocentric person. This is obviously a relationship based on more or less delusional phantasies about this ‘boyfriend’ — phantasies that directly reveal the minimal extent to which she had worked

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through her primitive triangulation, as well as her enormous differentiation/non-differentiation anxieties. Her defence against these is psychotic disavowal, promptly followed by projective identification. It was only when we had been able to talk about the situation in the sessions that she realized that she knew hardly anything about his life: he is a foreigner, apparently divorced or separated, with one or two children (she does not know how many), whom he has abandoned together with his wife in his own country. The relationship was soon in crisis (and so too was Daphne) because of what she sees as Pablo's sadistic demands and suggestions, in both the sexual and the personal relationship between the two of them. She tells me about this when the relationship is already practically over; however, her symbiotic—adhesive needs are so intense that she simply had to engage in this relationship despite all the warnings given to her by her own ego, her capacity for judgement and her 'internal analyst'. That is why she hid the fact from me, with an unconcealed wish to triumph over me in the attempt. The 'outcome' of her difficulties with loneliness and isolation was the psychotic, or symbiotic—adhesive, relationship.

Breaking off the relationship, with the resulting loss, is now more complex, owing to her profound need to cling to another of these characteristics — similar to her previous attempts at forming relationships — as well as to her concealment of the relationship in the analysis. The phantasy of mourning for the loss of Pablo and the relationship is almost impossible to accept, especially on account of the need to supplement it with another mourning process with intensely persecutory characteristics: in addition to possible mourning for the loss of the supposed relationship, other mourning processes have already been triggered by the narcissistic wound entailed by this new failure, as well as by the collapse of her manic attempt to triumph over me. In other words, a mourning process bearing the stamp of manic defences (involving little in the way of working through) looms, together with a greater tendency to negation, disavowal, splitting and projective identification. This mourning is supported by very primitive idealizations (both of Pablo and of her own capacity to form and maintain a relationship); it is a mourning process rooted in narcissism and in its offspring, pride and arrogance — a mourning process dominated by paranoid—schizoid processes of working through (and hence rooted in excessive splitting and disavowal). It is a type of mourning process which, by virtue of its severity and retaliative tendencies, the ancient Greeks were already obliged to relive each year in some of their paradigmatic tragedies, such as *The Trojan Women, Oedipus the King or Antigone*.

Daphne is on the verge of another psychotic decompensation. There are nights when she does not sleep; she spends her days at home, mostly in bed; she has stopped going to work and to her classes; and she has even missed some sessions, while failing to ask the psychiatrist to change or correct her medication. It is perhaps this second mourning process, the one resulting from the narcissistic wound, which cannot be worked through at this juncture, that is the factor most responsible for her difficulty in contacting the psychiatrist or communicating with me in any other way in the sessions — communicating in a form other than her stereotyped pride and anger with

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me — attitudes which she 'dramatizes' to a considerable extent with loud cries and declarations whenever the opportunity arises in her sessions.

In the session to be described below, after entering the room with this stereotyped posture and attitude, and her mannerisms exaggerated even further, she tells me:

'I feel just the same … I felt awful because, at my class at the university, we commented on a film, a film of psychological violence — or at least, that's how I experienced it — called *Time of the Wolves*. I don't know if you've seen it, but look, Jorge [She calls me by my first name, affecting a familiarity and free-and-easy manner which is not real and which she does not feel.], this film is pure psychological violence. I can't stand it. And last night, when I slept a bit — or not, I don't know — anyway, I had a horrible dream. In the dream *I was pregnant with Pablo's child. And now I think I can't go on with my postgraduate course; my life is in ruins … Then I was about to give birth, but I had a very strange, weird physical sensation, but one that was very conspicuous. The waters were supposed to come, but they didn't … Eventually, what came out was an enormous turd … My mother told me that such things sometimes happen and I felt utterly ashamed and mortified … After the turd, came the child. It came out on its bottom: it's much easier that way than face first…* At any rate, that's what happens in the dream. *A child comes out, a foetus, a foetus-child covered in blood and afterbirth. I think to myself: what am I going to do with this? I have the child and he has washed his hands of it — yes, Pablo has washed his hands of it. But I didn't care* [A typical mania-like attitude on Daphne's part.], *because I felt able to care for it all by myself… I was going to call it Eloy … And then the child seemed to be handicapped … I felt guilty, very guilty; it was horrible. It's because of smoking so much, I thought!'* [As in each relationship crisis and, to an even greater extent, in her psychotic crises, she spent the day chain-smoking, up to three packs a day, utterly compulsively.]

'Then the child improved … And I thought how nice it was that it looked like its father… Today I saw Pablo at the university, and I was astonished, as if hallucinating. I imagined him looking wild and thoroughly weird … This can't be right, I thought … it is absolutely, absolutely horrible … And there I am listening to him talking and walking … and I felt like telling him: 'You've made me pregnant' … That's impossible, because I took precautions. But sometimes, when he was about to come inside me, I said to him: "No way." I thought maybe I wasn't strict enough with him, and he came inside me … Next morning, I felt happy: I'm not pregnant! What I can't bear is that my life has been ruined, alienated, by the baby … And the fact of being pregnant by him, and his washing his hands of it … It's a nightmare. But the good thing about all this — the good thing — is that I felt capable of being a mother: that's the good thing about it all. I felt capable of bringing up this thing that had come out of me … I think this business of his having a daughter, of his having a daughter and taking no interest in her, in either of us … Suddenly I recall the vomiting scene in the film, when the husband is killed …'

The few interpretations I was able to give her at this time obviously focused on her sense that, in engaging in this relationship, she felt that she

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‘had produced a (big) turd’ [a colloquial Spanish expression for ‘made a “cock-up”’ — i.e. a big mistake]. This patient's associations and images were often scatological, expressed freely and without inhibition … or with an excessive lack of limits. For instance, on the three or four occasions when she told me about her first intercourse, the description conspicuously emphasized the moment … when her partner noisily broke wind.

The type of mourning process under way was on the one hand too persecutory and on the other too excessively marked by the manic reaction for any approach to reparative elements concerning the loss to be possible. Yet this mourning process seemed to be too projective, psychotic and non-containing for any possibility of its bearing fruit in the form of internal changes directed towards development.

However, the appearance of the foetus-child may refer to something deeper that had indeed been set in train within her with the improvement and stabilization of the last few months. But it could also be the result of a manic pseudo-working-through of the second and third stages of these two overlapping mourning processes, with the aim of disavowing the sadness and even the shame attaching to these two stages, or of dissociating the anger and sense of disintegration that invaded her whenever she thought she might meet Pablo at the university. She contracted acute, short-term psychotic symptoms simply by imagining such a meeting or, worse, if she happened to meet him in reality. These became so bad that she even stayed away from the university for weeks on end.

At this point in the session, I confined myself to noting the wish to bear fruit, to grow in her capabilities and internally, and to be a mother, and how this wish might get mixed up with obscure situations and relationships which neither she nor I could understand, but which she could not stop to think about or to bring up here. I told her that she had such a profound need for someone very, very close to her that she could sometimes neither choose nor heed her own fears and warnings or those of the analyst inside her … (A few days later we *were* able to some extent to explore the thoroughly ambivalent nature of the child, which was partly the fruit of reparative advances and partly a manic denial of her difficulties in the fields of relating, sex and being a mother.)

So I believe that in a situation of psychotic mourning — and in this case it seems to me that there are two instances of mourning, which, moreover, are very much intertwined — the possible transference interpretations of the situation must be considered and reconsidered over and over again. This is firstly because of their uncertainty: with what part of the self, which is terribly fragmented at this time, will she listen to them? Secondly, since the dynamic is infiltrated by psychotic processes, there is an additional risk that the interpretation might exacerbate her delusional nuclei or defences. Alternatively, by confusing her, it might contribute even more to her psychotic disintegration. The mourning processes did indeed become increasingly paranoid in the ensuing days, with the paranoid delusion extending to people *who failed to look after her — or did not look after her properly* when she needed it: her brother, her flatmates, etc. The result was that she treated them with her usual ‘haughty contempt’ and distancing. She had serious

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arguments with the flatmates, which culminated in their ejecting her from the flat. At any rate, this entailed mourning processes experienced in a more paranoid form and therefore with greater depth and self-integration than those experienced in a symbiotic—adhesive relationship. In accordance with the progress of her internal organization and her capacity for containment, I draw her attention on a number of occasions to the confusion between what she thought about Pablo and what she actually knew about him. I also help her to give names to the various situations that she tells me about, including those relating to her own or other people's jealousy.

The acute crisis diminished in a fortnight or so, but left her in a state of manifest instability of the self and subclinical psychosis. Once again, with the help of the treatment, her parents coming to stay in Barcelona, and her medication, she was able to hold out until the holidays, during which she went home.

January Session (The Third after the Holiday with her Parents in her Home Town)

Among other things, she brings me a dream: '*The other day I dreamt I was in the toilet;* well, you already know that the toilet is a problem, or something very special for me … I can't go to the toilet just anywhere, but only in my own home or my parents' house … And if I want to go or think I shall need to go, I hurry home so I can go there …'

I make use of this communication to throw a little light on some of her motley range of urination-related customs: she can squat for hours on the toilet, massaging her urethra and clitoris with her hands, in the way, she says, that her mother explained to her.

> 'Then I dreamt of a baby a few months old that slips away from me while I was in there, sitting on the toilet. It slips away and splits into pieces. But the good thing is that not only does the baby split into three pieces, but its face also splits into three pieces, each with its own umbilical cord. And everything goes off, slips away, disappears …'

She then falls silent, as if overwhelmed, without producing any associations.

I endure the silence, which is followed by some unclear, circumstantial comments. As the session progresses, I note her fear of falling apart and that things might slip out from inside her, which might sometimes be babies — valuable things — or shit which may or may not be something she values.

It seems to me that the dream clearly reflects her current fear of disintegration, of splitting into pieces. In other words, it very directly conveys the processing that a healthier part of her applies to the activity of her psychotic part, which cuts everything into pieces and causes disintegration.

All the same, she is apparently able to receive my words, and so I continue to tell her that it seems to me she is telling me of her need to find safe, calm refuges where she can join up with herself, get in touch with her own body, and become integrated, perhaps even by means of physical sensations; that perhaps she has to do all this in an attempt to reconstruct herself when she feels upset, threatened, or confused, as she does now in the conflict with

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Pablo, or when she feels persecuted by other people or even by me. In view of her clinical situation and her real dependence on her actual external parents, alone as she is in a city like Barcelona, I decide to desist for the time being from any exploration of the triangular character of the manifest content, which in my view has to do with her severely altered primitive triangulation and Oedipus complex.

The following sessions (on which I cannot report here owing to lack of space) were dominated by moments of confusion, disjointed moments of paranoia, irruptions of mania and clear reminiscences of the Oedipus complex as altered by psychosis — of altered primitive triangulation mixed with subsequent oedipal repression.

Session of Ten Days Later

She is very annoyed with me when she arrives for her session. She says that I am making her crises worse, that she is going to set a time-limit for me and, if not, she will break off the treatment. All this is announced in her tone of infantile pride, but in this case it is less coherent and joined up than on other occasions. Then, after a tense and violent silence, she brings me another dream:

> 'I dreamt of a place we had to escape from, and we were escaping, because the sea was reaching people and dissolving them. I was the one who was responsible for stopping it. If the water reached them, they dissolved and fell to pieces, even turning into little threads or strings, like strings of paint. There were various obstacles that had to be overcome — obstacles or tests … We reached a house, a house full of bars and structures, like the ones I made, but with more space between the bars and structures. A group of us reached it and managed to escape, and we arrived in a lecture room. A class. A place that was very, very high up. Right at the top, there was a dam and everything was smashed to pieces and dissolved into a liquid that poured down … And I knew that if you fell from up there you would dissolve, and I was in the class, but on the very edge of this place, right up on high. The teacher asks me to explain and I make jokes: Wow! There I am on the point of falling down and I say: Phew! That really is a … a … *[Nightmare, I suggest?] No, no, but it's very strange.*'

The crisis is coming on apace. Already there is virtually nothing to cling to, no way of unifying herself, so as not to sink into the mire: everything is liquefying and dissolving, like herself, as might happen to the material of the sessions … That is what I tell her in a number of extremely cautious consecutive interpretations.

In this case, it would, in my view, be highly inappropriate to talk about sexuality, loss of control, orgasms, oedipal aspects and the like, apart from the fact that there is no associative basis for doing so — particularly in view of her clinical situation and her being alone in Barcelona, because she leaves her session without going further away. Towards the end of the session, I incline towards some very cautious indications and an attitude of containment.

Next Day's Session

'Every day I feel more afraid of meeting my childhood friends, the ones from my home town, when I'm there. Or even when I'm here — Olga, Irene,

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friends from my childhood and teens … I had a dream about that; I think it's about that. A dream: *We were going to their village. Everything was very, very natural, very real, very much as it is. And it seemed that we were going there, but in reality the landscape is different, somehow different, it has changed in some way ... There's a sort of beach with a house, and a path runs from the house to the beach. The house looks like one we used to see on outings with my parents* … But in the dream it seemed to symbolize *us being at a sort of booth at the entrance to a place, and then we went along a kind of mountain path, because the house was closer to the road... And it was a reference point between one place and another ... Sometimes it was like a full school. Or one that had been abandoned. And then*, in the dream, *we went down to the beach ... And everything turned grey, the weather was utterly grey, sunless, always grey, as if it was getting dark. My two girlfriends were there, and the tide came in and we had to be careful not to be gobbled up by it, as there was a cliff at the end that blocked our way ... To get away and avoid the cliff, we had to cross a strip of sand, and it was dangerous ... One of those strips of sand that then get covered by the tide. The feeling was like the sea in the other dreams ... But this time there was something more, I don't know ... Or less*… I don't know, I don't know, it was different, with something peculiar, with … Something I don't know how to describe, either in the dream, or whatever; I don't know what it's like and why I feel that way … Something peculiar, with … *In the end, it actually swallowed us up, swallowed up my friends. It swallowed them up, but not me, it didn't swallow me up ... I tried to grasp them, but when I was about to get hold of them, they dissolved, like cartoon figures ... Was it true or was it a joke?* Were they people or was it a joke? I thought about it, and I have thought about it many times …*I was afraid because they were swallowed up ... Then they managed to get out*, but that was the part that frightened me most … [Is she telling me that the sea swallowed up Olga and Irene?] No: I was with other people I did not know, and they were all swallowed up, all of them …'

I note that the dream/phantasy/delusion, although clearly threatening (and with catastrophic threats), is more confused, and more confusedly expressed than at other times, even on the level of language. I fail to understand many aspects both of the sequence and of the patient's associations and questionings — something very common in acute and sub-acute psychotic crises, even though the contrary is often asserted in a particular kind of scientific literature. I am afraid that the psychotic disintegration is far advanced. Furthermore, her way of experiencing her reality of being alone and being left all by herself — that fewer and fewer people are with her in this world — is extremely delusional …

So, fearing that her psychotic disorganization might progress further, I ask her directly why she came late today, which was very unusual for her — except when she is having a psychotic crisis.

She replies evasively (and hence demonstrating the capacity for another type of dissociative process, involving less disavowal): '*Because I did not have to get…'*

I refuse to be quiet, and insist: 'But are you better?'

'Yes, today I got up.'

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This is tantamount to a declaration, utterly different from her splitting and dissociation of the previous sessions. Now we can talk about how, on the other days, she stayed in bed, not even making herself anything to eat, submerged in confused delusions/dreams/phantasies of disintegration… This provides us with a foundation for seeing her fears of being devoured by the sick, disorganized and disorganizing part of herself as real and extremely worrying to her. In the past, whenever I spoke to her about this subject she reacted by an aggressive attack on me and by refusing to go to the psychiatrist, but this time, albeit more or less confusedly, she is able to recognize that she is disorganized and afraid of getting even more disorganized … She says she has decided not to see Pablo again, and therefore not to go to the university for a while, until she recovers:

'All this has been very hard, very hard for me … everything I went through with him … yet it's hardly anything compared with what I'm going through after breaking with him … And he still approaches me, calls me, and sends me messages … I just don't know how … I don't know how …'

'… to get out of this situation,' I say, completing the sentence for her. 'To manage to say no, to avoid being so upset by it, to get yourself together again … How to get back to the safe house of your childhood, with your parents, with the clear path to the beach, to life … I think you are struggling not to drown in spite of all the obstacles and tests that you do indeed have to go through, and all alone, without the help and direct comfort of friends, parents, and safe places from your infancy, both inside and outside … And above all, feeling that you have put yourself in this danger, on this beach closed off by the cliff with the danger of drowning, being devoured, or falling apart, behind my back, trying to hide it from me …'

In my interpretation, made in stages, I am referring directly to the transference and her attempt to triumph over me. At first she is annoyed and responds angrily, as on many other occasions … I say nothing, but do not take back my interpretation — as I certainly would have done if her protests had led me to feel that it was wrong. I remain silent and, in my subsequent interventions, make it clear that I stand by what I said, but that I am not insisting on it. At the same time, I stand by the requirement that she should again visit the psychiatrist we agreed on at the beginning of the treatment, whom she had been to see a few days ago, while, however, partially concealing her clinical state from him.

Her tone in the session gradually becomes more cooperative and the organization of her language clearer. A slight, fragile, and unstable improvement commenced from this session on.

The Dream of the Teacher with Recurrent Cancer

My next illustration is very different. It involves a series of severe, overlapping instances of mourning in a patient with a stabilized psychosis (of the kind termed by some authors, including **Cullberg [2006]**, a 'recovered psychosis'). Inevitably, these mourning situations were experienced at first in the paranoid—schizoid position, with a risk of psychotic decompensation. However, with the aid of the reparative aspects of the patient's personality

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and that of the treatment, it progressively became possible to work through them, at least partially.

I shall call this patient Esther. At the time she was 53 years old. Her history of treatment with me dates back nearly two decades, during which I can recall at least two acute psychotic episodes. She was admitted to hospital for one of these. The second was contained by daily sessions with her psychotherapist and changes to her medication, as well as family support. Both involved a highly developed delusion and a mania-like state of mind. Three months after commencing her intensive psychotherapy, she had an acute mania-like, megalomanic psychotic crisis. (She believed herself to be 'a great researcher/discoverer. She knew that a fascist group had organized against her. Everything tallied, everything was definite, but, but …' A spark of lucidity caused her to doubt whether it really was definite, 'absolutely definite').

In the second psychotic crisis, 'the same group, or another one, had conspired to help her', without of course consulting her. She experienced this supposed help as particularly dangerous and obscurely invasive. In this case, even the psychotherapist was a member of the persecuting group in her paranoid delusion, which fully satisfied the criteria of a schizophrenic disorder as described in the DSM. Fortunately, there were two therapists who were familiar with the process taking place in her; at this time, I was performing the secondary tasks of 'organization of the treatment' and prescribing drugs for her, and was able to encourage the 'reconsideration' of the psychotherapist in the patient's phantasies and delusions.

During one of her periods of psychiatric hospitalization, the duty doctor had had some tests carried out which subsequently confirmed that the patient was suffering from a serious autoimmune disease, from which she would probably have died by now — except that she improved spectacularly so that she currently has only six-monthly check-ups, as even the test results are almost normal.

In 2003 she fell ill again, this time with what we used to call a 'psychosomatic' disorder — in this case, a dangerous blood dyscrasia. Both when this was diagnosed and later, when she suddenly needed surgery in **2005** for a malignant tumour of the breast (for which, in addition, a further operation also proved necessary), the accumulation of losses and mourning processes that were difficult to work through (and would have been difficult to work through for anyone) was on the point of triggering a decompensation in her. However, this did not occur. I shall therefore describe below some of the stages in their working through, which was marked by her reparative capacity, notwithstanding her psychotic clinical situation and the severity and accumulation of losses, which suggested the likelihood of psychotic development of both the mourning processes and the clinical situation.

I should first point out that the patient, in agreement with her psychotherapist, terminated her psychotherapeutic treatment some three years ago. I wish to draw attention to this because it is something I do not usually recommend, but I did not dare oppose it because it may also have corresponded to a need in the psychotherapist, who had become so emotionally involved with this patient that I felt he had made this decision because he

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needed some ‘relief’ (although, to my way of thinking, once one begins a psychoanalytic treatment with a patient correctly diagnosed with ‘schizophrenia’, one must be prepared for it to continue ‘for life’, albeit not necessarily with the same intensity and frequency of sessions). For this reason, since there had been no problems of dosage or variation of medication for perhaps ten years, or any doubts or conflicts, we switched to a programme of monthly sessions with me in accordance with the therapeutic model of ‘containment’, or ‘open follow-up sessions’ occasionally using the technique of ‘ultra-brief psychotherapy’ (Tizón et al., 2000). The patient is continuing her usual employment in her difficult job in which she comes face to face with the public; throughout her life she has hardly ever had to take time off work, except in the most acute crises.

Session from Mid-October

‘I am in a state of crisis. You already know I'm taking tamoxifen [an anti-tumour agent], and it's horrible, really horrible. It has all sorts of side-effects on me: sweating, funny tastes, which are sometimes unpleasant and sometimes like coffee or alcohol.’

I reflect how difficult it is to work through these bodily sensations, ‘halfway’ between the physical and the mental, between the well-defined and the confused, in someone who tends very much towards delusion and psychotic interpretations.

Furthermore, at precisely this time, she learned of the death of Amelia, the friend with whom she had had a homosexual relationship, and with whom she still used to correspond. Moreover, Amelia died of cancer — another loss that was very difficult to work through.

Then again, her partner had to apply urgently for invalid status owing to a serious sensory disorder. What is more, he was an artist so this is another situation calling for complex working through.

As if all this were not enough, she is suffering from severe tendinitis, possibly associated with the repeat operation on the malignant tumour. So she is virtually immobilized and ‘down’ — and this in someone who, both in her basic posture towards life and by virtue of her psychotic nuclei, has always made extensive use of action, of the ‘evacuative relationship by action’, of (controlled) ‘enactment’ as a form of delaying, projecting, dissociating or otherwise dealing with situations that could not be worked through. This is a lifetime tendency on her part, which I, as her therapist, have succeeded in supporting with limitations and with as much care and containment as possible on my part.

‘I feel very down and unable to do anything active; it's horrible, horrible, doctor. I don't know how I can stand it … And then, on top of everything, when I get these bouts of sweating …’

Complying with what she has ‘almost requested’, I suggest a temporary increase in the number of sessions, to one a week, at least until things start to become clearer to her, until she can to some extent get used to all these losses and changes. Contrary to what might be feared, the patient stabilizes to some degree and resumes some of her social activities and walks, ‘as

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I can't go to the swimming pool' (another form of therapy I suggested to her some years earlier, with which she is continuing more or less regularly).

Session Dating from Mid-January (Three Months Later)

Instead of tamoxifen, she is now on a new drug which has far fewer side-effects and 'lets me do what I want and can: to concentrate on my thoughts or not, according to how I feel … And the tendinitis is much better with my rehab (that is, with careful activity and use of her senses). But now I'm coming down again with the other thing, the blood disorder … Well, not really. I felt ill and the tests were not so good, but now I feel better. I think that with our thing [what we are dealing with together], mentally I am much better, and that is why the blood situation has also improved — goodness knows how. Or maybe it's the other way round, I don't know, don't tell me how, I don't know how. But listen, I feel better. And I'm sure the tests will turn out well. But tomorrow I have an appointment with the blood specialist, and each time I see a different one — I've had four so far — and then I'm afraid that we'll look at previous tests, the other illness, together with the cancer, and that they'll give me cortisone again. But cortisone makes me feel very, very bad. Not only do I swell up and get fat, but I become very anxious, very strange, I don't know … and when I stop taking it, it's almost worse. I'm afraid that, for the sake of my health, they'll give me cortisone while I'm having the tests, so I'll have to take a complete course … And I don't want to … What is more, that cousin of mine, the Yank, came to see me … He's at home with me, for ten days … He's not a bad person, but I can't stand him: all the time he goes on about Cuba, talking like an idiot about Iraq, defending Bush …'

What she is really afraid of is a lack of elaborative capacity on the part of the doctor. I could interpret this as a projection, the result of mourning processes in the psychotic position or, at least, in a paranoid relationship. Yet the patient seems to me to be so much in contact, and has on occasion described to me so well the depersonalizing atmosphere of the unit concerned — as opposed to the personal attention and containing capacity experienced in the oncology unit — that I do not see projection as the dominant factor; instead, it is an appropriate perception of the contemporary technical reality of our health services. Furthermore, I know something about the psychological and psychopathological effects of cortisone and corticoids — for example, that those carrying psychological and somatic risks should not be prescribed (after all, the patient is receiving treatment for cancer).

One possibility is for the two of us to sketch out a plan to avoid the lack of containment and help in working through which she experiences in some of the medical services with which she is involved. My basis for this is the capacity for working through which she is now demonstrating in her resumption of contact with what it meant for her to be diagnosed with cancer, the surgery and repeat surgery, the feeling of being pushed around by the medical services, etc. At first, she experienced all this in the paranoid—schizoid position, with splitting predominant. Now that she can talk about it, she engages less in splitting and therefore dissociates much less. In this

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way, even in such difficult and overlapping mourning processes, she avoids lapsing into massive projective identification and the consequent delusional persecution.

As stated, I therefore decide that the way forward now is to help her get her bearings in this difficult health-related reality which she is experiencing. For this purpose, we consider the possibility of having the tests done privately, and then presenting the results to the haematologist. I can help her arrange this. In this way, if her perception of her body signs is correct (as in fact turned out to be the case), the tests will be normal and the course of corticoids will be avoided. But if the tests show something amiss, she will not be left defenceless: the course of treatment will be inevitable and furthermore justified.

In the midst of these fears and the arrival of the Yankee cousin, she proves to be very changed, but with an island of hope emerging from so much conflict: she has decided to return to work, which she thinks she will be able to do in the near future if, as she feels, her tests turn out well. After all, she and I both understand the 'therapeutic' effect her difficult work, 'face to face with the public', has on her.

Session of Seven Days Later

'I feel much, much better … The improvement is continuing. I've had the tests and I'm sure they'll turn out to be normal. And last night I even had a dream. You know I never dream; well, I never or hardly ever remember dreams, but this time I did. And not because it is nice or easy. But it was very, very graphic… I dreamt that *I was walking along a road ... I've been walking for some time ... it's a long, long road, with lots of bends, ups and downs ... All of a sudden it starts getting dangerous, more and more dangerous: the bends are more dangerous and, in particular, some roots start coming out of the road — roots that distort it and crack it open; it looks as if they are going to get the better of it and break it up ... And I run and run along this road ... Further on, I see a bridge ... A bridge with a roof over it, like the ones you see in some countries ... There are some bridges that I like very much, that I've always liked very much ... and I go inside ... But the danger is that the bridge, or rather the roof over it, might cave in. It might cave in on top of me. It will fall on my head. And I feel afraid, very afraid, because I know that the roof might fall in on top of me…* Then I woke up in a terrible sweat — sweating like hell, but this time not because of the tamoxifen, as the new drug doesn't make me sweat. I think it's because of the anxiety in the dream. But I'm fine, aren't I, doctor? I feel fine, just imagine.'

'Thank you for setting my mind at rest,' I say to her. 'You are doing something with me that you could not do with the haematologist: you are trying to convince me that, although you are in danger and feel seriously threatened, and even dreaming about frightening things, that does not mean that you are ill. I think you are trying to convince me of that, but I agree: if you have been able to dream it, and, what is more, dream it so clearly and descriptively, that means you can now get a bit closer to all that loss and all that danger … Not like at other times — for example, when you were

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diagnosed with the cancer, and you were unable to talk about the subject here and could hardly even think about it …'

Esther agrees understandingly, her beautiful blue eyes shining with happiness, and laughs ironically when I (humorously) thank her for her attempt to set my mind at rest — 'for calming down Dr Tizón, in case he gets anxious at my anxiety'. She then gives me some more details about the roots that were tearing up the road, but these now seem to me to be more artistic and less frightening …

Analyst: What about the bridge with the roof over it? Maybe *The Bridges of Madison County?*

Esther. No, I wasn't thinking about that …

A: And the Yankee cousin: is that where he comes from?

E: Yes, he lives in one of the eastern states, but I hadn't thought of that … I think he's a 'rightist' and a pedant and I can't stand him, but that's all …

Given the lack of associations (and the failure of my own), I then think that this is a direct symbolization of her head — her 'roof' — given that this patient's symbolizing capacity is so well developed. We are now able to talk about the dream as an expression of this period of her life, when she feels so threatened by roots and evils which might break up the path of her life from within. Moreover, they could do so on both the physical and mental level, causing her mind/roof to cave in. Yet, as she says, she feels better: that is why she can dream such an accurate and poetic summing up of the reality she has been living and experiencing in the last few months … This is a good illustration of the fact that she is experiencing at least a part of her mourning processes with the healthiest part of her personality, in the 'reparative' (or, in Kleinian terminology, 'depressive') position **(Klein, 1957)**.

Care-Related Epilogue

In conclusion, I should like to sum up some of my present views on the psychotherapeutic treatment (with psychoanalytic psychotherapy or psychoanalysis) of patients of this kind. The general context of these ideas overlaps with earlier contributions, which recommend devoting more open and emotionally receptive attention to mourning processes in patients with psychosis. In my opinion, when working with such patients, we must bear in mind a number of basic principles of combined therapy for the psychoses, which I defined, for example, in **2006** and **2007a** (Tizón, **2006**, **2007b**), under the heading of *TANC*, a Spanish acronym for 'treatment adapted to the patient's and the family's needs in the community' (cf. **Alanen, 1997**; **Alanen et al., 2000**; **Edwards and McGorry, 2002**; **Johannessen et al., 2000**; **Martindale et al., 2000**; **McGorry, 2000**; Tizón, **2003a**, **2006**, **2007a**, **2007b**, **2008**).

- o *An essential requirement is treatment or psychological help for the family (and micro-social) group* or, at least, the conduct of periodic family interviews for the purposes of 'hygiene' and 'containment' (**Alanen, 1997**; Mari and Streiner, **1998**; **Martindale et al., 2000**).

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- The possibility of *group techniques* must be considered from the beginning, with both patients and/or the family and extended family and with the micro-social group and elements of the 'social network' (**Alanen, 1997**; Johannessen et al., 2008).
- Another requirement is to explore, utilize and integrate the help provided through the *social network*, as well as the (appropriate) reconstitution of this network and '*extrapersonal levels for containment*' **(Tizón, 2007b)** — in particular, work or school relationships.
- Agreement is necessary from the beginning on the support of *a psychiatrist*, on the *hospital to be used should admission be necessary*, and on who would decide on hospitalization and when.
- If *psychopharmaceuticals* are used, *priority must be given to psychological treatments* (unlike the usual approach in many 'northern' countries), especially during the first 'episodes' (**Alanen, 1997**; **Alanen et al., 2000**; **Cullberg, 2006**; Tizón, **2003a**, **2004b**).
- *Individual psychological treatment* is essential in all phases of psychosis (the type of treatment will vary according to the specific patient and family) (e.g. **Alanen, 1997**; **Alanen et al., 2000**; **Gleeson et al., 2008**; Johannessen et al., 2008; McGorry, **2000**; **Tizón, 2004b**, **Yung et al., 2004**).
- *It is important to explore and treat or rehabilitate the patient's specific deficiencies on the neurocognitive and social levels and those of relationship* by an approach based on full integration of bio-psycho-social, neurocognitive and stress-vulnerability models (**Cullberg, 2006**; **Frith, 1992**, **2005**; **Johannessen et al., 2006**; **Weinberger, 1987**; **Zubin et al., 1992**).
- Therapists require systematic, periodic *spaces for working through* (to contain their own anxieties) (**Alanen et al., 2000**; Tizón, **2007a**, **2007b**).

As to the *objectives* of these *combined treatments*, which include psychoanalytically based therapies, the seemingly frequent one-sided attempt to eliminate anxiety and 'positive' symptoms (hallucinations, delusions, behavioural disorders, etc.) should be avoided. From this point of view, as I have tried to show in the two cases described above, the need to preserve 'social adaptation' above all else should not be a prime objective of patient care today; nor, however, should we concentrate on psychotherapies directed towards the interpretation of the supposed meanings of the symptoms and symbols used by the patient. Even more dangerous are those 'psychoanalytic feast days' made up of disproportionate, arbitrary and risky uses of the counter-transference and transference interpretations — although we are admittedly often left with no other resource than to apply our always very partially understood countertransference in our approaches. On the contrary, perhaps the different types of therapists involved might now be able to agree that the objectives should be early attention and help with development, facilitation and working through of separation/individuation in at-risk situations (primary prevention), early integrated treatment (secondary prevention, which must include psychological and psychosocial treatments, even in acute

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crises), and the recovery or, at least, rehabilitation of those damaged or lost capacities, as the nodal point of tertiary prevention.

To this end, the *objectives of any integrated psychotherapy* within these integrated treatments — within an actual '*treatment adapted to the patient's and the family's needs in the community'* (Tizón, **2007a**, **2008**) — should be at least the following (**Alanen, 1997**; **Alanen et al., 2000**; **Gleeson et al., 2008**; **Johannessen et al., 2008**; **Martindale et al., 2000**; **McGorry, 2000**):

- o Helping the patient with difficulties of relating to and separating from his family. If the disorder has already become chronic, trying as far as possible to maintain these capacities for relating and linking.
- o Working on these patients' conflicts of trust/distrust.
- o Keeping the emotional capacities of the patient, his family and social networks as active as possible, even if this is frequently inconsistent with the first two objectives (and of course with any kind of reductionist perspective on the treatment as a whole). Work on the patient's mourning processes, whether real or phantasized, delusional or realistic, is a fundamental aspect of this objective.
- o Helping patients to preserve their capacity for relating and their relationships (number, variation, quality, depth, etc.).
- o Helping patients to develop strategies for containing crises and relapses, and hence for confronting their fear of these.
- o Working together with the social micro-group and family on the tendency towards loss of control and the fear of this loss, which is one of the foundations of such relapses.
- o In general, helping the patient and his social micro-group to make more realistic adaptations that take account of real difficulties, but without uncritically accepting the biologistic and despairing myths about the disorder. Once again, work on the patient's processes of mourning and working through is fundamental to the achievement of this objective.
- o Helping the patient to develop a more integrated, more secure identity (self) and hence to differentiate, including differentiation from the other people he needs.
- o That is to say, helping with family differentiation and differentiation of the patient (in his interlocking separation/individuation processes).
- o Providing the designated patient and the family with means of self-care. As with the other objectives, this must be done while respecting and encouraging the care capacity of the subject's natural environment and community social network.

Within this '*treatment adapted to the patient's and the family's needs in the community', psychoanalytic psychotherapy* should be practised using *technical principles* differing in some respects from those applicable to other kinds of

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patients and situations — for instance, the principles set out below (**Gabbard, 1994**; **Gleeson et al., 2008**; **Jackson, 2001**; **Kernberg, 1992**; **Rosenfeld H, 1964**; **Rosenfeld D, 2007**; **Searles, 1986**; **Segal, 1986**; **Silver, 1997**; **Tizón, 2007b**):

- o Making the construction and preservation of the relationship the principal focus of the treatment.
- o Two other associated requirements: preserving emotional capacity and preserving the capacity to relate to others.
- o Adoption of a more flexible setting; this is much less important or drastic today if we are able to work as a genuine therapeutic team, in truly 'integrated therapies'.
- o However, in each case it is important to try to maintain the optimum emotional and physical distance (for therapist and patient alike).
- o A prime consideration, after all, is that the psychotherapy or psychoanalysis should not only be emotionally active but also provide containment.
- o The therapist must act as a 'container' for the patient, including on the level of physical presence and availability of the external setting.
- o The therapist's interventions and indications will on occasion cause him to adopt a role similar to that of an 'auxiliary ego'. At any rate, it is advisable in such cases to consider in advance whether other members of the team might be in a better position to undertake such interventions.
- o Honesty, integrity, containment, simplicity, and openness are some of the other difficult personal and technical characteristics that must take priority.
- o For this reason, particular care must be taken with the level of interpretations, at least in the three fields of complexity, degree of symbolization, and when and how to include the transference and countertransference.
- o At certain times the therapist must respect the patient's wish to be 'ill' and not try to force him to connect with reality.

Although these principles can be set out schematically in this way, it should not be supposed that either they or their application are so clear that they should be taken as 'canonical'. On the contrary, my perception is that the psychoses and the psychotic parts of the personality still give rise to doubts of all kinds within us, and compel us to make profound changes in our general view of psychopathology on the one hand and therapies on the other.

Translations of Summary

Trauer und Psychose: Eine psychoanalytische Sichtweise. Der Autor versucht, einige grundlegende Modelle und Konzepte zu Trauerprozessen bei psychotischen Patienten zu entwickeln, davon ausgehend, dass Verlustsituationen und Trauer entscheidende Momente in der Psychoanalyse, Psychotherapie und therapeutischen Ansätzen im Allgemeinen sind. Weiterhin erinnert er uns daran, dass "Trauerprozesse

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bei Psychotikern" nicht immer "psychotische Trauerprozesse" sind, das heißt, dass sie nicht notwendigerweise im Rahmen des klinischen Bildes einer Psychose auftreten oder ein solches zur Folge haben. Diese Überlegungen werden anhand einer Reihe von Sitzungen und Vignetten von psychotischen Patienten in psychotherapeutischer und psychoanalytischer Behandlung erläutert. Theoretisch ausgedrückt scheint es in diesem Zusammenhang von entscheidender Bedeutung zu sein, im Rahmen einer speziellen psychoanalytischen Psychopathologie einen beziehungsorientierten Ansatz mit einer aktuellen Sichtweise von Trauerprozessen und affektiven Verlusten zu verknüpfen. Eine grundlegende Bedingung auf der klinischen Ebene ist es, die Rolle zu bestimmen, die psychoanalytisch orientierte Behandlungen in kombinierten, integrierten oder allgemeinen Therapien spielen, wenn man mit psychotischen Patienten arbeitet. Zu diesem Zweck werden am Ende dieses Aufsatzes eine Reihe von Prinzipien und Zielen für solche Behandlungen umrissen.

Duelo y psicosis: Una perspectiva analitica. Se intenta un desarrollo de los modelos y conceptos básicos acerca de los procesos de duelo en pacientes con psicosis partiendo de la idea de que las situaciones de pérdida y duelo son momentos claves para el psicoanálisis, la psicoterapia y, en general, las aproximaciones terapéuticas. En segundo lugar, querría ayudar a recordar que no siempre los 'procesos de duelo en psicóticos' son 'procesos de duelo psicóticos', es decir, que ocurren o dan lugar a un cuadro clínico psicótico. Se exponen, para ello, varias sesiones y viñetas de dos pacientes con psicosis en tratamiento psicoanalítico y psicoterapéutico. Desde el punto de vista teórico, en este tema resultaría fundamental combinar una perspectiva relacional de la psicopatología psicoanalítica especial con una perspectiva actualizada de los procesos de duelo y pérdida afectiva. En el ámbito clínico, resulta fundamental determinar el papel que los tratamientos de base psicoanalítica han de jugar en las terapias combinadas, integrales o globales de los pacientes con psicosis. Por ello, el trabajo termina proponiendo de forma esquemática una serie de principios y objetivos de los mismos.

Deuil et psychose: Une perspective psychanalytique. L'auteur tente de développer quelques uns des modèles et concepts de base liés au processus de deuil chez des patients psychotiques en supposant que les situations de perte et de deuil sont des moments clé en psychanalyse, psychothérapie et des approches thérapeutiques en général. Deuxièmement, il nous rappelle que 'les processus de deuil chez les psychotiques' ne sont pas toujours des 'processus de deuil psychotiques'; c'est-à-dire qu'ils ne se passent pas forcément à l'intérieur de, ni donnent-ils lieu à, un tableau clinique psychotique. Ces idées sont illustrées par un certain nombre de séances et vignettes concernant deux patients psychotiques en traitement psychothérapeutique et psychanalytique. En termes théoriques, il semble dans ce contexte d'une importance capitale de combiner une approche basée sur les relations dans un cadre de psychopathologie psychanalytique spéciale avec une perspective mise à jour des processus de deuil et de perte affective. Au niveau clinique, une exigence fondamentale est de déterminer le rôle joué par les traitements basés sur la psychanalyse dans des thérapies combinées, intégrées ou globales lors du travail avec des patients psychotiques. A cet effet, l'article est terminé par une esquisse d'une série de principes et objectifs de ces traitements

Lutto e psicosi: Una prospettiva psicanalitica. L'autore tenta di sviluppare alcuni modelli e concetti di base relativi ai processi di elaborazione del lutto in pazienti psicotici, sulla base del fatto che situazioni di perdita e di lutto sono momenti chiave per la psicanalisi, la psicoterapia e gli approcci terapeutici in generale. In secondo luogo, egli ci ricorda che 'i processi di elaborazione del lutto in individui psicotici' non sempre sono 'processi di elaborazione del lutto psicotici', cioè non avvengono necessariamente all'interno o non danno vita a un quadro clinico psicotico. Queste idee sono illustrate da un certo numero di sessioni e vignette relative a due pazienti in cura psicoterapeutica e psicanalitica. In termini teorici, sembra di vitale importanza, sotto questo aspetto, combinare un approccio basato sulla relazione — all'interno di un contesto di speciale psicopatologia psicanalitica — con una visione aggiornata dei processi di elaborazione del lutto e di perdita affettiva. A livello clinico, un requisito fondamentale è la determinazione del ruolo che dovranno ricoprire le cure basate sulla psicanalisi in combinazione, a integrazione o nell'ambito di terapie globali nel trattamento di pazienti pscicotici. A questo scopo, il saggio

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si conclude con la descrizione di una serie di principi e obiettivi per questi trattamenti.

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Article Citation [Who Cited This?]

Tizón, J.L. (2010). Mourning and Psychosis: A Psychoanalytic Perspective[1] [Duelo y psicosis: Una perspectiva psicoanalitica]. *Int. J. Psycho-Anal.*, 91(6):1337-1361

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