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The clinic of psychosis: a case study

A clínica da psicose: um estudo de caso

La clínica de la psicosis: un estudio de caso

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This is a case study carried out in 2018. It aims to describe the proposal for the care of a patient with a psychotic psychic structure. The case comes from the proposal of psychoanalytic care in a social clinic, in the individual and group mode, for a period of more than eight years. Group meetings and individual sessions took place weekly. In group mode, with the participation of four analysts, there was also a social triad: patients, mom and dad. In the individual mode, the relationship took place as an analyst-analyzed. From a little participatory beginning in the group and in the individual sessions, the patient (Rebeca - fictitious name), evolved improving her socialization, her family relationship, and even her professional issues. The psychosis clinic is an arduous task, but Rebeca managed to position herself and detach herself from the family. Currently, she is working, has maintained good social contact with the other members of the therapeutic group (*Grupo Vida*) and with her co-workers. This clinic is captivating because, in some way, the bond with patients remains; it is an endless analysis, which requires courage and determination from the analyst. The importance of the viability of the psychosis clinic is pointed out, in the psychoanalytic proposal, via active transference.
Descriptors: Psychoanalysis; Psychotic disorders; Therapeutics.

Este é um estudo de caso realizado em 2018, com o objetivo de descrever a proposta de atendimento de uma paciente com estrutura psíquica psicótica. O caso é oriundo da proposta de atenção psicanalítica em uma clínica social, no modo individual e grupal, por um período superior a oito anos. Os encontros grupais e as sessões individuais ocorriam semanalmente. No modo grupal, com a participação de quatro analistas, havia além uma tríade social: pacientes, mamãe e papai. No modo individual, a relação se dava analista-analisando. De um começo pouco participativo no grupo e nas sessões individuais, a paciente (Rebeca – nome fictício), evoluiu melhorando sua sociabilização, sua relação familiar, e até mesmo as questões profissionais. A clínica da psicose é uma árdua tarefa, mas Rebeca conseguiu se posicionar e se descolar da família. Atualmente, está trabalhando, tem mantido um bom contato social com os demais membros do grupo terapêutico (*Grupo Vida)* e com seus colegas de trabalho. Essa clínica é cativante porque, de alguma forma, o vínculo com os pacientes permanece; é uma análise interminável, que exige coragem e determinação do analista. Aponta-se a importância da viabilidade da clínica da psicose, na proposta psicanalítica, via transferência ativa.
Descritores: Psicanálise; Transtornos psicóticos; Terapêutica.

Este es un estudio de caso realizado en 2018, con el objetivo de describir la propuesta de atención a una paciente con estructura psíquica psicótica. El caso proviene de la propuesta de atención psicoanalítica en una clínica social, en la modalidad individual y grupal, por un período de más de ocho años. Las reuniones de grupo y las sesiones individuales se celebraron semanalmente. En la modalidad de grupo, con la participación de cuatro analistas, había además una tríada social: pacientes, mamá y papá. En la modalidad individual, la relación era la de analista-analizado. Desde un inicio con poca participación en las sesiones grupales e individuales, la paciente (Rebeca - nombre ficticio), evolucionó mejorando su socialización, su relación familiar e incluso cuestiones profesionales. La clínica de psicosis es una tarea ardua, pero Rebeca logró posicionarse y desprenderse de la familia. Actualmente, está trabajando, ha mantenido un buen contacto social con los demás miembros del grupo terapéutico (*Grupo Vida*) y con sus compañeros de trabajo. Esta clínica es cautivadora porque, de alguna manera, el vínculo con los pacientes permanece; es un análisis interminable, que requiere valor y determinación por parte del analista. Se señala la importancia de la viabilidad de la clínica de la psicosis, en la propuesta psicoanalítica, vía transferencia activa.
Descriptores: Psicoanálisis; Trastornos psicóticos; Terapéutica.

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INTRODUCTION

Psychoanalysis does not agree with the generalization of cause and effect. In psychosis, the subject becomes disconnected with the psychic reality, "*a hole, a failure, a breaking point with the structure of the outside world, which is filled by the piece brought by the psychotic fantasy*"[1].

In the Freudian perspective at first, work with the psychosis clinic was contraindicated, at the same time that this possibility opens up, with reservations that it is necessary to think about changes in the psychoanalytic method, so that this treatment becomes possible: "*Psychoses (...) are unsuitable for psychoanalysis, at least as it has been practiced until now "*[2].

The difficulty encountered was not exactly on the side of the psychotic, but on the side of the analyst in the transference. Pointing out that the aphorism of delirium is the attempt to cure or solve psychosis, that is, there is a movement by the psychotic towards stabilization. However, the specificity of transference in these "narcissistic neuroses" would make its analytical treatment unfeasible[3].

In psychosis, there is no symbolization, the subject experiences it. The psychotic literally interprets what they think, the thought is lived ipsis litteris, there is no representation. They live what they are. The words are real. "*Delusion has the function of reconstruction, what we consider to be a disease is actually an attempt to cure*"[3].

The specific mechanism of psychosis would be rejection (*Verwerfung*). And, what characterizes the difference between neurosis and psychosis is that in the first there is a conflict between the Self and the Id, while in the second the difficulties are in the relationship between the self and the external world[4-6]. Both in neurosis and psychosis there is a loss in the relationship that the subject establishes between self and reality[6]. This departure from reality is characterized by:

> *In neurosis, the self, through repression, suppresses the drive that comes from this. In contrast to the neurotic, which restricts only a portion of reality, in psychosis there is a radical rejection of this that characterizes its pathological structure. Due to the flight of the self in the relationship with the external world, there is a predominance of that or, in other words, of the unconscious, in its manifestations*[4].

The libido has two destinies, one part is in the self and the other is invested in external objects (caregiver), however psychosis is retained only in the self. There is no investment in an external object, so the establishment of transference in psychosis is of a different order, it requires a different management[6].

It is not a question of refusing transference in psychosis, but this is different from transference neurosis. The Freudian proposal does not advance much on this theme, but it is brought in the Lacanian view, which points out that what is established between the analyst and the psychotic patient, is that the analyst will always be in the imaginary specular position. The psychotic superimposes subject and object, and speaks as a human subject of his position as an object[7].

According to Lacan[1], "*psychoses are, if you like - there is no reason to afford to refuse to use that term - which corresponds to what has always been called, and what legitimately continues to be called, madness*".

Lacanian psychosis is a different structure from neurosis. There is a defense mechanism in psychosis called foreclosure. The word foreclosure comes from the legal field and means the deprivation of a faculty or a right that, because they were not executed in due time, became obsolete[7]. However, before being restricted to legal use, these expressions in French, meant "*exclude, deprive, expel, prevent, ban, omit, cut*"and even "*arrest outside, close outside, throw away, reject*" "*Foracluir*" is what has left the scene, which is not symbolized, which is meaningless[7].

But both Freudian and Lacanian leadership urges the analyst to listen to what psychotics have to say about themselves and their illness. This listening to the psychotic discourse

proposes to affect the possibility of treatment, or rather, a clinic of psychosis. The subject of psychosis, even with their sometimes disconnected speech, brings with them a universe, with contents that also deserve to be heard.

The concept of transference is fundamental to psychoanalysis, especially in a work that aims to investigate aspects of the treatment of psychosis and, as in any analytical practice, the work happens from the subject.

The libido has two destinations: one part is in the self and the other is invested in external objects (caregiver)[8]. The psychotic addresses the analyst as one who is in the place of what they hear. It doesn't matter what they say, but they know someone has to listen to them. From this listening, the analyst gives a non-logical sense of what is said, but a sense of importance of what is said by the patient. In neurosis, the patient puts their analyst in the place of the subject supposed to know and in psychosis, the patient tells the analyst what they know about themself.

In psychosis, the analyst is a witness to the position that their psychotic patient occupies in the world. The psychotic analyst cannot extrapolate their condition only from those who listen, they do not prescribe conducts, but they point out ways. The one who directs the treatment is the psychotic, as they themself interprets their symptoms from their delusions. And, the analyst listens, this possibility that the psychotic has a place.

The transfer is an exchange, the patient takes place and the analyst returns it. This is a love event, in the Lacanian sense: "*To love is to give what you do not have to someone who does not want it*"[9]. The transfer is only possible when the analyst respects the uniqueness of each patient. It is the analyst's desire that will allow them to respect this uniqueness. If there is no interpretation in this clinic, there is the analyst's desire.

In the clinic of psychosis, the analyst works much more with the production of delusions that come from the unconscious that is open. Delirium is an attempt to reestablish, a process of reconstruction[10].

"*The psychoanalyst must not retreat in the face of psychosis*", does not present itself as the heroic sense of sustaining this burden, but in order to produce, on the one hand, knowledge that helps to solve the problems that psychosis imposes on psychoanalysis and, on the other hand, reducing the obstacles it presents through transference[11].

Outbreaks, delusions and hallucinations are defenses to deal with the invasion of the great other. The analyst offers a space for listening to these delusions and hallucinations, literally interpreting what the patient tells.

The analyst's first attitude is to seek to understand the patient's clinical structure, this will allow the analyst not only to think about the treatment coordinates, but also to observe what place he occupies in this relationship[12].

Obviously, the analyst will not be restricted to nosographic descriptions, because that says nothing about the subject in question, but having a structural diagnosis can help in understanding the subject, based on listening to his singularities.

The analyst must occupy the position of "*secretary of the alienated person*", allowing the creation of a bond, so that the possibility of working with the subject arises from it[13].

Since the beginning of the creation of psychoanalysis as a field of knowledge, albeit in an incipient way, transference appears as a decisive plan in which the paths of an analysis take place, that is, what is known of the analysis is its beginning and its end. The middle of the road is permeated by the transfer.

The transferential field can be understood as an affective sharing plan through the playful encounter, which favors the production of meanings for the experiences of each of the partners in the analysis[14].

In the analytical relationship and group possibility, the active transference in the clinic of psychoses, the "north" is the quality of the affective encounter between analysts and analyzed. In group activity, analysts are catalysts of affections, while one takes the place of the paternal

figure, another takes the place of the maternal figure, oscillating between these two places the affections circulate[11].

Analysts must offer the patient the possibility of experiencing, experiencing life, the relationship established between the patient and the analyst is that the analyst is not restricted to talking about the patient, but he listens and talks to the patient[15].

The analyst promotes a pact through speech, a pact that symbolizes their absences, presence and the limits of their actions and behaviors. In this way, "the analyst attracts to themself the fragmented parts of the psychotic unconscious, bordering those parts of loving affection and meaning. This force gradually attracts other objects to its surroundings, giving them other bearable meanings"[11]:

> *Active transference is a voice that includes itself, that speaks, punctures, leaves a mark and has a name (psychoanalyst, psychiatrist, medicine, group, family, yes, no and others.) That the patient summons. It is a loving summons. It is the relationship established between the analyst and the patient with a psychotic structure under the aegis of pure desire that redirects the libidinal fragments of the psychotic. It paves the way for active interpretation, which is direct and unquestionable, offers love, and imposes limits. Interpretative action helps the psychotic to understand their imaginary universe and differentiate it from the real world, allowing them to remain in reality most of the time, away from delusions and hallucinations*[11].

It is argued here, that the clinic of psychoses by psychoanalysis is possible and that the transference takes place in a different way from the neuroses. Thus, this article aims to describe the proposal for the care of a patient with psychotic psychic structure.

METHODS

The present work was carried out in a social clinic of a psychoanalysis research center, in 2018. The person described in this case study was selected due to the characteristics of her clinical case.

The individual sessions took place weekly (for more than eight years), she also participated in a group analysis at the clinic itself. Some biographical data that could allow the recognition of the real identity, have been omitted and/or altered in this report in order to preserve her anonymity.

In the direct quotations from the transcripts of dialogues in the therapeutic sessions, the real name was replaced by a fictitious name, in the case of Rebeca. The clinically relevant source of information was the session diary, in which the therapeutic meetings were transcribed.

For this study, the case study methodology was used, which implies an effective participation of the analyst, first of all as a research subject.

RESULTADOS

Rebeca is 44 years old, single, and is part of a family of six siblings. Her father is of Arab origin, therefore, coming from a severe culture, with very strict moral rules; her mother is Hungarian and, (according to Rebeca), became a concentration camp prisoner at the age of 14 and has had psychiatric disorders since when Rebeca was 3 years old. As of that date, she was admitted with a diagnosis of schizophrenia to an institution on the outskirts of São Paulo. Shortly thereafter, her father married the secretary, with whom he had a daughter, and this second wife also has severe psychiatric disorders.

Rebeca was appointed by a participant of *Grupo Vida*in 2011. At meetings, she was always very scared, introspective, her eyes were very wide, and she hardly spoke. Her inner despair was so intense that it was overflowing. She tried to make sure the environment was safe. Any movement was followed by her startled look. She stayed quiet in several meetings, did not

participate, did not speak, even when asked questions. There was also a total neglect of personal hygiene and minimum self-care.

When she started attending *Grupo Vida*, she was on a lot of medications, was being accompanied by a psychiatrist for about twenty years, and using Carbolitium and the latest generation antidepressant. However, her speech was disjointed and very confusing; in some sessions, she only uttered disconnected sentences. She was very sleepy, with a foul odor, trembling and very hungry.

Often, she did not take care of her body, showed repetitive behaviors of rubbing one hand over the other and then touched joints such as knees, ankles and elbows. Until, one day, she came to me to see her individually, because another patient in the group had reported a noticeable improvement with individual sessions. I agreed to answer it. At first, it was very difficult for both of them. She feared to trust me, and I, for my part, had never seen a case of psychosis individually.

At *Grupo Vida* meetings, she tried to hide that she had problems, she didn't want anyone to know about her difficulties, even though they were present, inscribed on her body: shaking hands, disconnected speech, constant irritability, high level of aggression. There was also a persecutory feeling - which she always reported in individual sessions - towards one of the therapists in the group.

As individual care progressed, Rebeca managed to make a connection between the persecutory feeling in relation to the referred therapist and the figure of her mother, regarding austerity and distance. In the sessions, she stated: the therapist is as distant from me as my mother. It is close and, at the same time, distant.

In the first year of individual care, she told her story fully stratified. It was difficult to understand and separate what belonged to her childhood from what was current. In the moments when she was referring to a boyfriend, there was a mix between reality and fantasy.

In the second year of individual care, she became more confident and calmer, showing consistency in group therapy, using medications and attending individual care. Concurrently with the individual service, she continued to attend the group. In group therapy, she began to understand that she could mirror herself in the group; she observed other patients, noted who had improved and who was not well and reported these observations during individual visits.

Although everyone was a reference for mirroring, she always spoke very badly of all the participants; there was always something to score, but with a critical, stern look. This second year was one of progress. Whenever asked, she was able to speak more clearly about her experiences to the group. In individual sessions, she expressed anger towards the whole family, who did not accept her as a free and willing human being and continued to feel persecuted by the therapist who coordinated the group.

In individual sessions, she was much more aggressive. The analyst positioned herself as the depository of this anger and, many times, she stood up threatening to physically attack her. In questioning her, the analyst told her that she could do everything in the setting, except touch me, under threat of not attending to her anymore.

In the individual analysis, Rebeca started to put pieces of her life together in blocks of related subjects, and her speech was more coherent. The analyst went into her delusions. When she calmed down, you could talk about it, trying to come to a possible understanding.

During the process of individual analysis and participation in the group, the patient got stronger, sought to develop other social activities, attended preparatory courses for public tenders, beauty and massage courses and learned to face her family, which for her was a battle to be won, since, every day, the family structure put their sanity to the test. Although she has seven siblings, father, stepmother and nephews, Rebeca feels that she does not find support in any family member. *Grupo Vida* takes the place of this family and the individual analysis has contributed to the appropriation of this space.

The group participants recognize their improvement, their efforts and their achievements. It seems that little by little, the patient renounces the struggle for an ideal family, enduring this kind of emptiness, which gave rise to the desire to become familiar with the group. Crossing this bridge, she gradually pursued new challenges, chosen by herself, as she wanted to build a family in the group, which is based on the family paradigm (father, mother and siblings), in which the affects circulate freely.

For the past two years, the work in the individual sessions has been to build options in which she can be interested and be useful, as it is her desire to have a job and be productive. She has two university degrees and her greatest aspiration is to work in the field of education. Currently, she is aware of what she can and cannot do and is trying to deal with her limitations, without the delusions of being a great teacher. During all this time, she tried several affective relationships, but without success. She dreams of marriage and the opportunity to live far away from her family, whom she considers to be largely responsible for her illness.

With the direction of treatment based on active transference, both in the group and in the individual session, what has been sought is to dismantle the impossible fantasies that she has, entering and leaving her delirium when necessary, seeking meanings that allow her to differentiate delusions and hallucinations of the reality that surrounds it.

It is understood that these delusions and hallucinations are, perhaps, a cry for help that Rebeca sends, seeking to find solutions to face life, the world and people. Rather than submitting to the caprice of the Other's gaze, demanding and perverse, the patient lessens enjoyment, and tries to restructure her relationship with others. She realizes that accepting her limits and living with necessary losses is the way to deal with her desires in a responsible way.

Therefore, the other is no longer so persecutory, to become a partner, but in another dimension, what she has been demonstrating in the analysis and in her relationship of affinity with the group participants. What is being tried, with this interminable and massive transfer, is to give her support and a certain security, so that she can be socially inserted in the world.

In the analysis, one dares to cooperate so that she perceives the environment and its possibilities. The analyst, when they support and wish to continue in this transferential relationship in the clinic of psychosis, must be aware that there is a very strong, constant and massive bond, a high demand, much more intense than those of a neurotic patient.

It is possible to observe her best social reintegration, participating more actively in the group, and even requesting more individual assistance, always in search of alternatives that make her happier.

In one of the last sessions, Rebeca arrives with a worried look and realizes that she wants to say something. She begins by reporting that her mission is to save the devil from death, because he is cursed by God, and she would be the only person who could help him. She reinforces this idea by saying:

The devil killing me, would have eternal life, that's what he thinks. By killing me he takes away the only life expectancy he has. Even because he kills me and then dies forever, because what you do for the other person comes back to you, and I live. God gave me the mission to kill the devil.

When the narrative ends, I ask her:*How long have you been having these thoughts?* She responds:

I got sick because I was unable to fulfill this mission, that God prepared me in a dream, I am afraid. That's what bothers me most, most of all.

In an attempt to understand her delirium, I ask her:*Rebeca, do you really think that God would give you such a complicated mission? What makes you think that you would be the one chosen to carry out this task that is so difficult?* What she talks about:

> *But I don't think that, it comes to me in a dream, I'm afraid.* I tried an approach: *I propose that we make a pact with God so that he can release you from this mission*.

Bearing in mind that she always reports that she does good things, and that what is done for good or for bad returns, then, who knows, God could free her from this very difficult mission?

For the development of a project about a book on *Grupo Vida*'s trajectory, participants were asked to each tell their life story, from their point of view. Rebeca liked the idea. Necessary care was taken, such as signing the Informed Consent Form. During four sessions, she related her story. It was a difficult exercise, she relived her story with each word, she went back and forth along tortuous and exhausting paths, it was as if she was putting a patchwork together. There was no predetermined number of sessions.

She was asked to talk about herself. It was up to her to choose how she would construct her account. The speeches constructed by Rebeca in the sessions had a very perverse content, making it evident that the patient is and has been a victim of psychological abuse on the part of her sick family on a daily basis. The statements were transcribed and, after reading, she was asked to say how she perceived her own story. Upon hearing her story, she starts by commenting that:

In hell, you suffer a lot.

For the first time, she utters a speech including the other and her problems:

If you focus on the other, then you cancel yourself, you cancel your problem, you are not focused on yourself, you are focused on the other. Oh, I'm sick, oh, I don't have a boyfriend. Speaking like that, you are making a hole in the ground and sinking into it. Now, when you focus on something external that is not yours, focus elsewhere and not on your problems, your life gets better. Because others also have problems.

After almost eight years of treatment, Rebeca's speech seems to show that she can see that the analyst sees her with possibilities to interact in society, that seeing herself, she can perceive the other. Another fact that corroborates this thought is her professional activity. She happily says that she was the best seller of the month and, with that, won prestige and red roses. She says that the team is very good, although many speak ill of her, but she no longer takes these aggressions for herself, and it became a lot of fun.

DISCUSSION

The psychoanalytic clinic teaches that psychic phenomena are common, and the variations occur quantitatively. Among humans, there are no substantial differences, qualitatively humans are similar.

Considering that in Rebeca group activities were used, the group in question has the permanence of analysts for a long period, which generated stability.

It was also observed that the presence of two more analysts with the coordinator of the group that led to the creation of long-lasting and secure bonds between patients and analysts. As time went by, the group took on the “family” shape and the coordinator adopted a role of father figure, which forbids something when necessary. The other collaborating analyst, on the other hand, occupied a more receptive, caring position, the maternal figure, and the other psychoanalysts joined the group as brothers.

Currently, they perceive and comment on the presence and absence of their companions, communicate outside the group, exchanging messages via Whatsapp, mobilizing themselves, in this way, to help each other at different times.

In the third year of service to Rebeca, the active transfer was already in place. This term brings the idea that the presence of the analyst can guarantee the psychotic his place as a subject[11].

In active transference, the analyst uses themself as a bridge, in the sense that they bring to the psychotic the connection between the real and the imaginary. And how is that done? Via affection. The analyst causes the active transference by presenting an object of positive affection so that the psychotic subject can introject the good object[11].

This transference takes place via language, the analyst builds a mosaic together with the psychotic, the flaws and cracks are not covered, but, in a way, it is possible for the psychotic to trace their story back. Active transference is a voice that includes itself, that speaks, punctures, leaves a mark and has a name (psychoanalyst, psychiatrist, medicine, group, family, yes, no and

others) and the patient summons when they evoke. It is a summons that happens, not by chance, but by something that can be called love[11].

There was a reference to Rebeca in her family, from her experiences at *Grupo Vida*. This group is an attempt to escape the traditional forms that are offered to the psychotic patient, as it offers the possibility for that patient to have a place in the world.

On the one hand, the aim is to stabilize the patient; on the other, the expansion of the possibility of creating social bonds, via active transfer. The analyst's active word allows the psychotic patient to have a truth to support their existence, the acting of love that allows one to believe in a truth: that the analyst is able to help them live. This imaginary becomes an attracting and organizing pole for the fragmented drives of the psychotic. The analyst's image will be introjected as the only figure capable of making him live[11].

The course of an analysis can be defined as the space and time for handling the transfer; that is, the psychoanalytic process is closely related to the variability of affectivity that circulates between analyst and analysand[16]. The analyst is willing to be used as a "tumbler", and offers themself as support for the most intense affective manifestations foreseen by the transfer, they will be rewarded with the overcoming of many of the "objective resistances", imposed by the standard treatment. Thus, "innovation" is to rescue the dimension of freedom from the fundamental rule, which has been largely lost throughout the process of institutionalizing psychoanalysis[16].

It is not a question of innovating the clinic, since Lacan, like many other psychoanalysts, had already been inventing handling with religious patients for many years[16]. As an example, it is interesting to mention Lacan's striking encounter with Marie de La Trinité, in which the patient, a Catholic nun, sought help for treatment, after a period of intense suffering.

Without taking into account the details of the case, Marie de La Trinité, in the period in which she seeks treatment, goes through the competence of several doctors, among whom Lacan stands out, according to her, for a differentiated ability to understand spiritual things. Regarding the experience with Lacan, she states:

> *There is nothing much to say about the treatment itself; unless, instead of confining myself to Freud like the previous doctors, he continually traverses the scales of human nature throughout the sessions* [...]*. I feel very safe with him, because he understands spiritual things, he does not eliminate them like previous doctors, on the contrary*[16].

This approach allows us to say that "the spiritual things" that Rebeca addressed, if well listened to by the analyst, can become a way of rectifying the narrative of the dream that she brings to the analyst. Instead of killing the devil, the patient agrees to celebrate a new pact with a God who can be demanding, but can also negotiate, collaborate, accept new proposals and possibilities. The analyst assumes the handling of delirium, positioning themself as the other who listens, and not as the other who demands it.

Listening, although they do not answer or advise Rebeca, the analyst thinks aloud, and is noticed by her as the other in the relationship, who offers support, something different from what she experienced in the past, delirious, in her relationship with her family, with the doctors, with *Grupo Vida*.

Therefore, the realization of the pact with God became a new experience, giving rise to a new approach to the challenges that Rebeca had and will have to face for the rest of her life, with the other in reality, with the different partners at work, in love life, in religion and others. She has to end evil, but by exterminating it, she becomes evil and will only be able to be well if she makes another pact. The acceptance of this pact reassures her.

At that moment, if she realizes that her face is lighter, she seems relieved, especially when it is said that delirium is a way that she finds to escape her own history and, at the same time, manage to live it.

It is against this pain that Rebeca fights. She says that she is relieved to have told them and that what the analyst said took a heavy toll on her, given that it would no longer be

necessary to do so. Psychotic manifestations, such as delirium or hallucination, are not immediate effects of a given cause, but consequences derived from the struggle waged by the Self, to defend against unbearable pain[18].

In another session, Rebeca raves that she is an angel and can protect Axl (lead singer of the band Guns N'Roses) even from a distance, comparing herself to him. The possibility of helping Axl, in a way, helps too. No intervention is made, because her delusion is a movement of life. The analyst keeps listening to the delusion and, in this way, the delusion keeps Rebeca moving. If you try to support the demand that comes over me.

It is considered that the concept of ordinary psychosis seems to be well suited to the Rebeca case, considering that it encompasses cases of compensated, unchained, mediated psychoses, in therapy, in analysis[18]. This concept comes from the latest Lacanian studies, which emphasizes that nosographic classifications hide what is unique in each case. Diagnosis in psychoanalysis is only an orientation for clinical management, as one cannot lose sight of the subject's uniqueness.

The semblant is the discourse of what is not, because, in fact, its function is to cover up the real, it is to speak of what it seems to be, but it is not. It is in the real that the psychotic constructs his discourse.

In the first instance, it can be said that psychosis is a structure. But what is meant by this definition? In a very simplified way, it is possible to state that psychosis can be diagnosed from transference, that is, it is not the presence of symptoms that makes us describe this or that subject as psychotic.

It is likely that you will have an asymptomatic patient, from the point of view of classical psychiatry and, however, in the work with the analyst, its structure will become evident. It can be said that what characterizes him as psychotic is their *modus operandi* in the world and its surroundings.

Grupo Vida is supported by a social triad: patients, mom and dad and, bringing this approach to individual care, a dyad is formed: analyst and analysand[19]. Only individual service is not enough, the group provides support and the mirroring condition that comforts them. A good psychosis clinic is based on the articulation between group and individual care, but, when choosing to provide individual care, the analyst must be aware that it can be requested at any time, and assess whether it supports this massive transfer and intense[19].

CONCLUSION

The psychosis clinic is hard work, but Rebeca managed to position herself and detach herself from her family. She is currently working, has maintained good social contact with the other members of *Grupo Vida* and with her co-workers. This clinic is captivating because, in some way, the bond with patients remains; it is an endless analysis, which requires courage and determination from the analyst.

In attending to Rebeca, the analyst was faced with her delusions, but was not afraid of them; faced and, she found herself supported and managed to make sense of the emptiness. Rebeca's great merit was her persistence in continuing the analytical process, fighting incessantly against the ghosts that plagued her.

In the *Grupo Vida*, her improvement is observed, the patient is able to place herself, talk about her difficulties, and hear the difficulties of others. The group takes the place of the family; however, it is in the individual analysis that she finds the support to move on. The combination of the pair “individual analysis and group work” constitutes a very productive and healthy space.

This study has the limitation of addressing only one case, but at the same time, it brings the possibility of understanding that analytical intervention in psychosis is possible, even if complex and that requires other instruments, different from the neurosis clinic.

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Silvia Herszkowicz contributed to the conception, analysis and writing. **Araceli Albino** collaborated in the writing and reviewing.

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