

## Review article

# Psychoanalysis in the hospital. Psychoanalytic interventions in a public health institution

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### ABSTRACT

For decades, psychoanalysts in public and private practice, intervene in many situations and face tasks that are clearly different from the classic stereotype of psychoanalysis. That is to say of Individual consultation(s) are normally conducted with the use of the divan and 45 minutes length. Although these tasks are often the main component of our practice they are sometimes view with suspicious and are alien to most “professionals” in this area of expertise.

These types of interventions to which we refer, adopt forms according to the times and the task they intend to play. They are the interventions that called Analytical Interventions, actions

whose identity signs would be at least two [1]. First the use of the word with its ability to influence the other. Second, the taking in consideration the effects that the Transfer promotes in the therapeutic relationship.

In the following work, through a clinical report, is intended to focus attention on Analytical interventions performed in a hospital setting. The intention is to reflect on the consequences in medical work and in the evolution of patients.

**Key-words:** *Psychoanalysis, Hospital, Public Mental Health Service, Clinical decision.*

### Introduction

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Although these tasks are often the main component of our practice, they are sometimes view with suspicious and are alien to most “professionals” in this area of expertise.

Psychoanalysts in general, are quite reluctant to adapt to methods that appear to work outside the acceptance orthodoxies. This new concept presents challenges in our reflections, in our training and our exchanges with colleagues.

These types of interventions to which we refer, adopt forms according to the times and the task they intend to play. These are the interventions that called Analytical Interventions, actions whose identity signs would be at least two [1]. First the use of the word with its ability to influence the other. Second, the taking in consideration the effects that the Transfer promotes in the therapeutic relationship.

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hospital setting. The intention is to reflect on the consequences in medical work and in the evolution of patients.

For practical purposes for this article, we will refer to this patient as Ramon. He is a 56-year-old man who was admitted to the Neurology Unit to undergo testing for a Korsakoff encephalopathy. Ramón was treated by one of us during the 16 days of hospitalization.

He worked as an official of the municipality of Murcia. In the last year his co-workers appreciated important changes in his behavior. Such changes consisted of; memory problems distractions and a disorganization in his functioning. Simple tasks he once performed competently and without incident, now became a detriment not only to Ramon’s own well-being, but to the well-being of his department as a whole.

Ramon was oblivious to the disorganized nature of his work. Although Ramon’s colleagues were unaware of this personal affair of his private life, this dramatic deterioration was clearly evident. After speaking with Ramon, The Department Head encouraged him to consult with the company’s physician. Ramon’s condition was so pronounced that the physician felt it necessary to personally accompany Ramon to the hospital for immediate analysis.

At this point, Ramon was admitted to the Neurology Unit for a diagnosis study on suspicion of serious alteration in memory and the possible onset of dementia.

As the Interconsulting Psychiatrist, it is common practice to share patients with Neurologists. A colleague of mine, who I will refer to as “Dr. X” is in charge of Ramon’s case. We share many points of view, enthusiasm for atypical or unique cases and we both have desires for research. We have conducted several joint clinical sessions as well as posting an article together.

One day, while making the rounds, I was on my way to treat another patient when I ran into “Dr.X”. *The outline of our conversation is as follows:*

*“Juan, I am involved with a very special case! This particular case is a man who is suffering from acute alterations in memory, perhaps an atypical form of memory loss. It could even be a case of Syndrome of Korsakoff but there is no history of alcoholism. It might just be malnutrition’s, a deficiency of vitamins.”*

Despite the enthusiasm shown by “Dr. X” in discussing the case, he did not request the interconsultation to the psychiatry service. I concluded that the organic origin of dementia would become clear and no intervention on my part would be necessary.

I must say, that I was completely surprised, to receive a consultation request, addressed to me, by another neurologist, three days later. However, this doctor does not share the same passion, nor possess a similar attitude towards the case studies in which “Dr.X” and I are involved. In any event, he still has my deepest respect as a medical professional.

Curious about this fact, I was prepared to see and hear not only the patient but also “Dr. Y”. He tells me that it is a strange case, atypical. Although it is clear that it is a neurological problem, because there is a clear alteration of the fixation memory, there are contradictory data. The first of which is not a drinker as should be supposed for its pathology. He is a strange man, lonely with hardly any social contacts in the last 17 years since the matrimonial separation. It is then when he moves to live in a neighborhood on the outskirts of the city

My first impression(s) regarding Ramon, is of a tall, thin and lean man, totally bald. Dressed in hospital pajamas who greets me with a strange familiarity. His sad look contrasts with the expansive nervousness he shows in the way to treat me. When I introduce myself, he says he thinks he knows me. He keeps moving and shaking his hands.

He appears to be impatient with my questions and is quick to provide answers before the questions are finished being asked. He does not know why he is in the hospital. The nervousness that I observe and that he also detects is attributed to the time he is losing when he is admitted, given that he has a lot of work to do.

Three days after admission to the hospital, Ramon was transferred to the Psychiatry Unit, which is a closed Unit, on precautions concerning flight risk. Although the Primary Neurologist is overseeing Ramon’s case, I have sessions with Ramon in an office of the Psychiatry Unit.

For Ramón and above all for his sister I know that he is the youngest of three brothers, two boys and one girl. The older brother died at the age of 50 years due to liver cirrhosis. He was diagnosed with schizophrenia. Ramón’s father was an alcoholic. The sister tells me that during childhood they witnessed the drunkenness and the bad temper of the father. He worked for Renfe. The mother was a housewife. Ramón, as the sister describes him, was always a lonely, self-sufficient kid, very reserved and jealous of his privacy. He completed high school studies but did not want to go to university. After several jobs, prepared an opposition getting a position as an administrative at the town hall. This is where he has developed his entire working life. The sister does not know about his friends and relationships. At 35 years he got married. The marriage lasted seven years. During this time his sister had little contact with Ramon’s wife. And he only had contact with her after the first years of the separation. A curious fact occurred when he separated makes me think about the type of relationship that established or who would be this woman for him. Ramón suffered first digestive disorders that forced him to be hospitalized. Later he suffered alopecia areata with total hair loss. After the marriage separation he lived for a while in his sister’s house, Later on Ramón set up his new residence in a place far from everything that until then had been familiar to him. His sister missed this exile (“there did not know anyone, and I do not know what was the reason for him to go there”).

When I see Ramón, every day, a strange and at the same time familiar phenomenon happens (I would say that something of the sinister sneaked in the interview). It seems like it’s always the first day. Ramón has fixation memory affected. He does not remember my name or who I am. In spite of this, he greets me with the familiarity of someone who has known me for a long time. His attitude to some extent is uninhibited, expansive, totally alien to the situation of internment that is living. He is always expressive, very gesticulating, with a tension and aggressiveness contained. This is only noticeable in the permanent beating of his closed fists, on the table, which accompanies the assertion of his affirmations. In the first interview held in an office of my service, suddenly I notice that the voice of Ramón is very similar or almost identical to that of Dr. Iniesta, the Neurologist who asks me for an interconsultation. I say to myself “if I close my eyes I could be listening to Dr. Y” (according to the inductive thinking that Pierce describes and Silvia Bleichmar talks about, I would say that what happens to me is an “inductive flash”). I’ll talk about this below.

In other interviews maintained, the same thing always happens. There is a false recognition, an appearance of familiarity in the encounter. Ramón is loquacious, although he gives the impression of a false attitude or false self. It becomes very difficult to access their privacy, because it always has the same affective. I cannot know what the relationship with his wife was like, what united them and what were the reasons for the separation. It does not clarify either the alopecia that it had, as it was, much less wishes to speak to me of the brother who died. Evade those issues with superficial answers.

One day I find him listening to the radio. I ask what station is tuning. He tells me that one that is called Revive that he likes

a lot, usually puts songs from the past. He talks to me about his passion for radio and how when he was young he worked in it. He was an imitator of voices. He managed to have a comic space, half an hour, on Saturday afternoons for six years. In this space he imitated famous voices. After telling me this, he imitates Alfonso Sánchez, the famous film critic, Jesus Hermida and Fraga Iribarne, some very well-known people in Spain.

Ramón has a very severe deficit of immediate memory and fixation memory, both anterograde and retrograde, but he is able to clearly remember past events. He also has a difficulty in recognizing facial faces. He fills the memory deficits with confabulations, so sometimes I can only know if what counts is true or false after contrasting it with his sister. She confirms the certainty of the story of the imitation of voices. He started with this hobby at 12-13 years. He had some success getting him hired on a local radio.

After staying 12 days in our Service, Ramón was sent to a Residence in Cartagena because he could not maintain self-care. After a month, through the social worker of the Hospital, we knew that Ramón adapted well to the residential environment. Surprisingly, he helped the rest of the hospitalized people by telling them that he was “Dr. Y”, a neurologist. I highlight the surprise at this fact because, clinically, Ramón lacks immediate memory and fixation to remember the name of “Dr. Y”

From this clinical case I would like to highlight two moments: The first one is when the “Dr. Y”, asks me for the interconsultation. A second moment is when suddenly I realize, without knowing how, that the patient, Ramón, has the same voice as the Neurologist, “Dr. Y”.

Regarding the moment of the interconsultation, I want to mention the changes that have occurred in medicine with implications in the subjectivity of the patient.

In recent years there has been a movement, unfortunately hegemonic, in favor of evidence-based medicine. This is related to a greater presence of managers and economic parameters both in the administration and in the clinic. On the one hand, through this sanitary management, it is intended to reduce health spending, avoiding the use of medications or therapeutic processes whose effectiveness is not demonstrated. On the other hand, this management appeals for reasons of equity. That is, avoid the so-called clinical variability and that all patients receive the same treatment regardless of the place of residence.

For this reason, the reception of the interconsultation caught my attention. In its description hardly varied from the comment made by “Dr X”. The fortunate clinical variability so maligned by the health authorities was present. Why do both doctors maintain a different approach to the same patient? Does this result in that only one of them considers the interconsultation? Subjectivity came into play, something reviled by evidence-based medicine.

As a psychoanalyst, and this condition is already questioned here, I know that behind a motive of manifest or conscious consultation is something unconscious, not deciphered, which corresponds to the doctor who consults. There is an unconscious demand addressed to me, that is, I am called as an interconsultant

psychiatrist, but also as someone who listens and works with the unconscious. In other words, I am summoned, by this neurologist, in transference of something that he knows but does not know what he knows. Something that has to do with him and with the patient he is treating.

Let’s think about the second moment mentioned above, when suddenly I realize without knowing how, that the patient Ramón, has the same voice as the Neurologist, Dr. Iniesta. How to explain what is happening here? Or what do I think happened to me?

I do consider that there is a predisposition or analytical attitude. Nasio says [2], the analyst’s ego is, first of all, a surface of perception for which the excitations do not differentiate between endo and the exopsychics. This line of thought is followed by Cesar and Sara Botella (2001, p.69), when they speak of “Session Status” as a special availability of the analyst.

What do I perceive? This brings me to the subject of “The Signs of Perception”, which Freud addresses; for the first time, in letter 52 [3]. This term appears as “**the ultra-clear,**” (**überdeutlich**)<sup>12</sup> in three texts, from 1898 to 1902 [4-6]. They are as follows: “On the Psychic Mechanisms of Forgetfulness” as well as “Psychopathology Of Everyday Life”, in particular when Freud talks about Signorelli’s oblivion and “Screen memories”. Later, in 1937, he returned to the subject with his essay “Constructions in Analysis”.

In the “Letter 52” Freud [3] refers to a first inscription in the psyche of the order of living in the pure state, which he calls signs of perception. For Freud, it would be that which is not communicable or memorable, the unthinkable in terms of a meaning-binding activity (that is, remembered in representational words), in short, it would be the unforgettable.

The signs of perception are thus dealt with modes of inscription, that cannot be transcribed spontaneously, and which may appear in the mind of the patient or the analyst, as fragments of gross psychic materiality, debris detached from an experienced real.

How does this thought arise in my mind? To explain it I will use abduction concept, studied by the American philosopher Peirce.

Abduction is more than a syllogism. It is one of the forms of reasoning next to deduction and induction. The contest of imagination and instinct is required for abduction. Pierce, in reflections after 1900, appeared in “Logic of Drawing History from Ancient Documents Especially from Testimonies” (MS 690, CP 7.164-255) and in “On three Types of Reasoning” (CP 5.171), proposes to understand abduction as a dynamic

<sup>1</sup> In his essay on “Screen memories” Freud describes a fair number of early memories of childhood “... they are mostly short scenes, but they are very **well preserved and furnished with every detail of sense-perception, in complete contrast to my memories of adult years, which are entirely lacking in the visual element**” (1899, p.309 SE. 3) “... **the peasant-woman cuts the loaf with a long knife. In my memory the bread tastes quite delicious**”..... “Do you suspect that there may be a connection between the yellow of the girl’s dress and **the ultra-clear yellow of the flower in your childhood scene?**” (1899, p. 311-312 SE. vol III)

<sup>2</sup> Freud traces other experiences of “ultra-clear” ideas to parallel processes of substitution. In “The Psychological mechanism of forgetfulness” Freud recounts his inability to remember a street name but notes that the house number “as if to jeer at me” was ultra-clear to his mind’s eye (p. 297, SE 3)

process in the elaboration of scientific explanations. The concept of abduction is transformed. It stops being an inversion of a deductive syllogism to be the expression of the creative activity of the scientist in the face of an unexpected or surprising situation.

Understood in this way, abductive inference would have a fundamental role in obtaining new knowledge. It is what allows us to propose a hypothesis that explains an anomalous situation. This opens the way to the inductive verification of the statements obtained deductively from the suggested hypothesis. Therefore, abduction will be the first inference that will guide our search for truth. It is like a flash of understanding, a jump over the known, a freeing of the mind.

Peirce refers to the surprising nature with which it comes to the mind of the scientist, as a flash, that is a product that emerges behind the voluntary-conscious activity of the thinking subject. It says verbatim: "The abductive suggestion comes to us like a flash. It is an act of insight, although of extremely fallible insight. It is true that the different elements of the hypothesis were in our minds before; but it is the idea of putting together what we had never before dreamed of putting together which flashes the new suggestion before our contemplation". (CP 5.181.)

Following the reasoning of Silvia Bleichmar [7] when talking about symbolization of transition, it is not a matter of thinking in the reflective sense, nor an act of unconscious reasoning, but of a sequence in which a piece of disjointed fragment bursts into the preconscious and operates as a detonator to produce a new assembly that ultimately appears in the form of an "abductive flash".

Unconscious elements, participate in the abductive ideological production. Something of the unconscious of the neurologist, and the unconscious of the patient was captured in that "suddenly realize that they had the same voice", something which makes it possible later, that someone like Ramón, who is not able to have a fixation memory, and that is in your emotional implicit memory, evoke and identify with the neurologist.

To finish explaining what he does, or rather what I do as a psychoanalyst in a hospital, I want to talk about an idea of Julio Moreno, an Argentinean analyst whom I had the good fortune to know personally, and who I think has a very interesting and suggestive theorization.

Julio Moreno [8] talks about the subject, and the inhabitant, and among them, he points out that there is a crucial difference as the interface that he describes between association and connection.

Julio Moreno says textually: "we could differentiate two configurations around the concept of the subject. One is relatively stable, a structural precipitate more or less fixed of our history and its accidents. Another is rather fleeting, varies with each presentation, with each practice or even with each link. The first queen in times of solidity, the second instead becomes increasingly important in liquid media affected by volatile changes" [8].

The existence of the human will thus pass between times in which it is presented as an inhabitant of a situation and others in

which it is can be considered a subject of the world. The journey from one to the other would be concatenated and depends on the stable or changing characteristics of its environment. Pure fixed subject of an absolutely solid world or pure fleeting inhabitant of a completely volatile situation, they would be unreal extremes. The first would elude all singularity and presentation not represented; the second would consider nothing "already given" and would inhabit a disorder without historical determination.

To work in the hospital as a psychoanalyst is to work as a subject with a filiation, in our case, a member of the Psychoanalytic Center of Madrid, which in turn belongs to the IFPS, a definitive member of a community that is inaugurated by the work of Freud. As such, I am a subject in the sense developed by Moreno and as such I occupy a designated place in the hospital that allows, for example, the Neurologist Y, consults me in transference for the case of Ramón, breaking what would be expected from the clinical guidelines and introducing his subjectivity and his personal history for my unknown.

But in the hospital, and I would say more, also in my practice private in front of certain patients, I find myself as an inhabitant of a changing situation, which is guided by the signs of perception, being able to recognize cohesions or connect traits. Once that happens, these connections can be diluted or acquire a certain degree of stability, perhaps becoming brands associated by a subject, both me and the patient, in their unconscious and personal work.

Can this position and this work of a psychoanalyst, in a public institution, help medical work?

Eric Laurent maintains in Position of the psychoanalyst in the field of mental health [9] that the analyst is not an official of the device, does not fall victim to a gear, but rather is placed as the person responsible for his decisions.

But we would say that such a position should not be only of the psychoanalyst, but of the doctor in general, with respect to the institution and its own patients.

If the function of a psychoanalyst in the hospital, is to take advantage of the occasion so that there are turns in the subjectivity, of those who consult and from whom important consequences for their lives may emerge

The doctor in general, and many psychoanalysts are doctors, is to be present with our own subjectivity, recognize us as subjects filiados, with a past, a history of their own and a knowledge not thought that will appear in many of our diagnostic or therapeutic decisions regarding the patient and far from being a practice invalidated by its clinical variability (the history of each doctor is particular and unique), in our opinion is responsible for that personal and subjective component that is always present in the patient's demand.

Aguayo [10] points out that Peirce's abductive method is present in the medical evaluation from symptoms, as well as in the classic stories of Sir Arthur Conan Doyle and Edgar Allan Poe.

This statement does not discredit the medicine based on evidence, because a coherence and certain standardization in the diagnostic answers is useful and necessary to guarantee equal

treatment and also the economic and savings component must be present in our professional practice.

But we would like to encourage a suspension of medical activism in favor of this current and a reflection on the personal aspects that the doctor-patient encounter holds. That every doctor has a psychic capital, available and enriching at the time of facing this meeting.

In the case that something personal and unconscious of “Dr. Y” has been described, it led me to interconsultation. Something that is part of their original unconscious possibly, that which Bollas [11] American psychoanalyst based in London has called “the known not thought”, which coincides in this sense with the descriptions made by the intersubjectivist psychoanalysts of the unconscious prereflexive (see Stolorow•) and that would be part of the implicit memory, that memory stored in subcortical centers when still the talamocortical beams are not mature and therefore cannot be fixed in the cortex and reproduced verbally. A procedural memory that we use without thinking about clinical decision making and that is bathed by past emotional experiences that connect us with certain unconscious aspects also (of the patient. This is what makes it possible for someone who cannot fix memories for neurological damage to remember “Dr Y” by having unconscious subcortical emotional records that resonate with the encounter with “Dr. Y” and that are part of an automatic response that, as Fonagy has pointed out [12], is stored in the amygdala.

In short, we believe that analytical interventions and the work of the analyst in the hospital assure a broader understanding of human nature on the part of the rest of the colleagues and the patient [13-18].

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