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AFFECTIVE MODULATION AND THE PSYCHOTHERAPEUTIC PROJECT IN SCHIZOPHRENIA

We would like to call attention to the ambiguous conjugation between diagnostic activity and the psychotherapeutic project in the area of schizophrenic syndromes. Each nosographic scheme can become an instrument to turn away or get closer to the patient. The discriminating factor is the use that is made of it inside the therapeutic relationship.

It seems useful to us to refer to diagnosis as the name that one gives when recognizing that a group of phenomena is connected, therefore meaning that the name is an invention that makes it possible to think of something and talk about it before we know what it actually is (Bion, 1963). Moreover, we repropose the evidence of the observer's participation in the phenomena that he/she observes: therefore, the diagnosis becomes something that is created by paying attention to phenomena seen while observing him/herself with the patient.

In such a light, recognizing a certain psychopathological form means not only paying attention to understanding the patient, but also to one's own countertransference tolerance. Thus, the base is established for a prognosis that is essentially a prognosis of the treatability. Speaking about a psychotherapeutic project in relation to patients diagnosed as schizophrenic also means evaluating those patient's possibilities of evolution. It seems that we can agree on the fact that such possibilities are mediated by the persistence of object relations, although distorted, and by the ability to experience depressive feelings, even if they are fleeting and scarcely tolerated.

No two schizophrenic patients are alike, writes Pao (1979), and we feel it is more appropriate to speak about schizophrenias than schizophrenia, to underline a polymorphism that comes not only from the observed symptomatological picture, but also from the multiplicity of the observer's points of view.

The disorientation that every schizophrenic patient (and consequently the field of schizophrenias) provokes in us can somehow be confronted by moving on different levels of observation and thought. These levels can be made up of possible nosographic schemes, of theories that back them up, of observed symptoms, or of feelings perceived in the patient and ourselves.

The prevailing impression is that symptoms are actions to show and to hide the nucleus of suffering and only that which "happens" between the patient and ourselves inside the therapeutic relationship (and by therapeutic relationship we mean not only all those in formal psychotherapy, but every doctor-patient relationship) can make the meaning understandable.

It might be useful to retrace the path of psychopathological schizophrenic theories, from Bleuler, Freud and Minkowski to today, and the oscillation between notions of "conflict" and those of "deficit", but we do not have the necessary space here, and we risk getting lost in the subject. Perhaps this is why every author chooses a thread to follow, as useful as Ariadne's thread, but with the risk of leaving out aspects of the clinical reality. However, the thread is also an expression of the individuality of search that views thinking about one's own resonance with respect to the patient as an instrument. So, although there is widespread agreement about some basic theoretical data, in the

therapeutic approach to the individual and the reflections that come from this, it is inevitable that one should focus attention on some privileged experiences, trying to construct or reconstruct the relationship of meaning, if not of cause.

As far as a nosographic scheme is concerned, with respect to a psychotherapeutic project, but perhaps to with respect every therapy and/or care project, we feel that one needs to lean toward a "structural" diagnosis, which allows one to gather the whole framework of the disturbance underlying the symptoms, according to Freud's affirmation that the diagnosis is what is left when the symptoms have disappeared.

A point which seems very important to us is the therapist's attention to psychosis in terms of a "path" more than a "state". The path concept may seem to contradict the more static terms just used, such as framework and structure, but perhaps in some cases it appears intrinsic to a given personality organization that cannot do anything except waver constantly between one symptom and another, in an exhausting attempt to save him/herself and the object.

The possibility of a "path" in psychosis suggests that an indication of systematized psychotherapy comes from the consideration of the point at which each individual patient finds him/herself along the path of the psychosis, in addition to the nosographic diagnosis and the attention to the structure of each single patient. This sense of rime justifies the technique of "combined" approaches in psychiatry, inside of which, not in a simple synchronic juxtaposition but in a diachronic sequence of different approaches, a project for formal psychotherapy can come to the front (with the schizophrenic).

While thinking about a possible link between psychoanalytical theories and the nosography of schizophrenic disorders, Freeman (1985) underlined how clinical situations and different outcomes suggest different types of alteration in object relations and, in particular, how psychotic onsets (and syndromes with a potentially more favorable outcome) do not indicate a loss of the object, but a persistence, although deformed, of it not unlike what happens in depressive psychoses, writes Freeman.

This is the main point of our contribution: reflecting on the importance of noticing me presence of a depressive feeling or at least an affective movement with respect to the possibility of establishing a therapeutic relationship. .

This brings up me much larger problem of me role of depressive moods in the whole field of psychopathology, a problem proposed many times, but never really cleared up. When we refer to the schizophrenic patient's anguish, we feel that the anguish is essentially centered on the identity and on me narcissistic cohesion of the Self: an anguish that reminds us more of Pichon-Riviere's "basic depressive situation" (1971) man of melancholy. But in patients who are less regressed to start with, or in those who have been reintegrated with pharmacological therapy and our attention, we may gather emerging feelings of a more clear-cut depressive coloring, and that is where phenomenological analysis offers the most useful resources. The depressive dimension can be seen through its decisive shades of meaning, such as allusion to guilt, thought of death, of min, and the feeling of inadequacy, which is to say the thematic expression of a confrontation with a disastrous self image. This image can sometimes be gathered among the ruins of psychotic omnipotence, or can sometimes lead to them. Or else, anxiety appears in transparency, through a phrase, through some behavior mat allows the therapist to feel or imagine the hidden power of the depressive feeling. The thought model adopted, as one gets closer to schizophrenic syndromes, gives proof of its effectiveness in operation, and has not only revealed the truth, but has produced it, writes Benedetti (1983).

Naturally, with every patient, the problem of tracing a hypothesis of a depressive economy in the map of mat single psychosis is posed, letting either me ability to reintegrate him/herself, or the regret for the delusion or me abandoning of the parts of me Self that seem devitalized, prevail. And it is according to the third situation that essentially depressive feelings lose a great part of their evolutional possibilities and are transformed or cross the border into those which are indicated as negative symptoms of schizophrenia.

Attention to the affective movements along the path of psychosis has as we know evoked me possibility of a phenomenological continuum that goes from depression to schizophrenia. For some cases, it is possible to follow Nacht and Racamier's idea (1959) of reading certain psychoses as catastrophic forms of defence against a feeling of mourning. On the other hand, the standstill in the evolution of me Ego and its alterations always seriously interferes with the possibility of the schizophrenic's tolerating depressive feelings.

The question that could come up is: is the fear for depressive feeling at the origin of schizophrenic fragmentation, or rather does the depressive feeling it emerge from the overcoming of this fragmentation in a potentially evolutive movement? Obviously, there are no definitive answers: every depressive movement in schizophrenic patients suggests different answers to us. This brings us back to the multiplicity of schizophrenias, but also to the point of considering depressive movements as or "Ariadne's" thread, not to theorize, but to move inside the therapeutic project with the individual patient.

One can think that, while the "indicator needle" of anxiety seems oriented toward the external world in the paranoid process or toward the zero of fragmentation in certain schizophrenic syndromes, the appearance of depressive feelings indicates its orientation toward the internal world to outline guilt. This may be guilt born of hate and envy, but it indicates an attempt at reconsidering the object.

When we think of the schizophrenic patient's anguish, we feel, as we said, that the anguish is essentially centered on the identity and the Self's cohesion, but the narcissistic reintegration mediated by today's pharmacological treatments allows us to note with more frequency those which we called depressive movements. Although they are not structured into a depressive syndrome, they command our attention and modulate the course of psychosis, and our therapeutic intervention, be it pharmacological or psychotherapeutic. What has always come out of this complex movement, partly perceived and partly imagined, and has scandalized people at the level of nosography, is the not uncommon conjunction of primary delusion and depression, which Weitbrecht indicated as the "apple of discord" in psychiatry. But as Minkowski (1927) reminds us, Bleuler, in his most advanced formulations, underlined chat the question is not whether it is schizophrenia or manic-depressive psychosis in each individual case, but rather «to what extent it is schizophrenia and to what extent manic-depressive psychosis».

The alternate vicissitudes of syndromes called schizoaffective or with other synonyms are well-known, and although treated like a dying species in D.S.M. III, they are more fully salvaged in D.S.M. III R. We want to underline the fact chat when we speak about the field of schizoaffective condition we are not referring to a diagnosis in a nosographic systemization, but to a sort of psychopathological "situation-position" chat can be picked up in different moments of the course of schizophrenia and can either lead to a specific diagnosis or not, depending on the presence or absence of points of discontinuity with respect to the most common schizophrenic syndromes. We, therefore, find the documented non-homogeneity of schizoaffective syndromes obvious, if they are examined in a follow-up that evaluates types of course and outcomes. In fact, looking at schizoaffectivity as a sort of situation-position (as we do), which can be primary, like a matrix, in the schizophrenic spectrum, but than can be lost or carried out again, means referring to a condition modulating the psychosis with respect to more crystallized stabilizations and more enigmatic positions of autistic withdrawal.

In short, considering the schizoaffective condition as a possible psychopathological position in the psychotic path is the same thing as paying attention to the affective movements in the schizophrenic patient. This allows us to communicate the experience of situation in which, even though there is a serious distortion of the function of reality externalized by delusion and sometimes by hallucination, the possibility of the patient's entering in contact, perhaps temporary, with the reality of the external world and his/her own feelings does exist. In these conditions it is possible for the patient to feel depressive anguish again, although it is difficult to tolerate and the patient is at constant risk of being thrown into delusion.

A particular evaluation must be made as regards the presence of manic traits in a schizophrenic patient. Even if we are used to considering every manic episode as an escape from the internal to the external world, (and therefore as an unfavorable condition as far as a therapeutic project is concerned), in some schizophrenic patients, however, the development of persistent manic traits represents a cohesive modality, an attempt at holding the Self together. In this case, the manic oscillation, more than an escape from internal reality, represents, instead, either the possibility of protecting it from excessive fragmentation or an attempt at building it up. Therefore, the therapist can find some support both in the patient's depressive and manic traits, intended as or shell protecting a fragile, cracked Self, which is, however neither fragmented nor completely closed to a relationship with the other (another person).

If the attention that allows us to perceive depressive feelings helps to start the psychotherapeutic process, it can also define its limits not infrequently. Racamier (1980) writes «what a schizophrenic can manage to do in order to live better is to accept and adjust his/her regressive movements, without fearing that the world is annihilated and the object destroyed because of this».

In Racamier's reflection, we see the results of therapeutic work and the resonance of deposited emotions, and not the expression of "giving up". Certainly, from time to time, an image can present itself in the therapist's mind: that of being in a wade into which, together with the patient, he/she has been led from the passage opened by the depressive feeling, but in which the anxiety itself does not seem to allow to go any further, like a climber on a rock face who can neither go up nor down. It's a position that is difficult to tolerate because of the mental pain that comes with it and that evokes the presence of suicidal ideas and, in both the patient and therapist, the regret far functions which were more regressive but less painful.

"Soldier Reiner" at a certain point of his journey inside schizophrenic psychosis says to his therapist Conrad (1958): «Don't throw me into that fearful doubt again! Let me go and I'll spend my life in lovely insanity». The problem is trying to find a conjugation every single time between the depressive feeling in the schizophrenic patient, its meaning in the psychosis and inside the therapeutic relationship, and its position in the patient's mental pattern, meaning by this the quality of his/her object relations and therefore the possibility of elaborating the depression.

«(...) When confronted with therapeutic results. It is useless to follow the myth of a hypothetical structural change – writes Manfredi Turillazzi (1988) – running the risk of wasting time and the chance of a symptomatic or behavioral change; that is, curing the patient in the medical sense of the word». After all, beyond any referral system, the importance of affective movements comes out in outlining the nosographic range of the schizophrenic spectrum and these movements have modulating actions which are fundamental in the path of the individual patient. They are like cornerstones, which once perceived bilaterally in the therapeutic relationship remain supporting points, even through failures and relapses.

However, the attention given to affective feelings picked up in the relationship and in our empathic perception contributes to the birth of a psychotherapeutic project with the schizophrenic patient, but it can also define its limits, case by case, indicating what we can do, what the patient can tolerate, what is useful for him/her.

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