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REFLECTIVE ANALYSIS ARTICLE

THE CLINIC NURSING CARE TO THE PSYCHOTIC SUBJECT BASED ON PSYCHOANALYSIS

A CLÍNICA DE ENFERMAGEM NO CUIDADO AO SUJEITO PSICÓTICO A PARTIR DA PSICANÁLISE

LA CLÍNICA DE ENFERMERÍA EN LA ATENCIÓN AL SUJETO PSICÓTICO A PARTIR DEL PSICOANÁLISIS

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ABSTRACT

Objective: to understand the clinical approach of psychosis performed through Nursing from the psychoanalytic referential. **Method:** this was a theoretical essay based on the works of Freud and Lacan in addition to publications in the field of mental health nursing. **Results:** we identified the concepts of listening, subject, and uniqueness as assumptions for this clinical approach. **Conclusion:** psychoanalysis can guide the clinical practice directing it to reflection about how events experienced by the subject are meant in his uniqueness; and how each one can represent their own psychic suffering. The intervention is made possible by listening the psychotic subject, welcoming his productions, writings, papers, and inventions; assisting in the process of building something that can function as a support for this subject to deal with his grief. **Descriptors:** Nursing; Mental Health; Psychosis; Psychoanalysis.

RESUMO

Objetivo: compreender a abordagem clínica da psicose realizada pela Enfermagem a partir do referencial psicanalítico. **Método:** ensaio teórico, realizado a partir de obras de Freud e Lacan, além de publicações da Enfermagem no campo da saúde mental. **Resultados:** identificaram-se enquanto pressupostos para esta abordagem clínica os conceitos de escuta, sujeito e singularidade. **Conclusão:** a psicanálise pode nortear a prática clínica, direcionando-a para a reflexão acerca de como os eventos vivenciados pelo sujeito são significados em sua singularidade; e como cada um vai poder significar seu sofrimento psíquico. A intervenção é possibilitada pela escuta do sujeito psicótico, acolhendo suas produções, seus escritos, seus documentos, suas invenções; auxiliando-o no processo de construção de algo que possa funcionar como suporte para esse sujeito lidar com seu sofrimento. **Descritores:** Enfermagem; Saúde Mental; Psicose; Psicanálise.

RESUMEN

Objetivo: comprender el abordaje clínico de la psicose realizado por la Enfermería a partir del referencial psicanalítico. **Metodología:** ensayo teórico, escrito a partir de las obras de Freud y Lacan, además de publicaciones de Enfermería en el campo de salud mental. **Resultados:** fueron identificados como presupuestos para este abordaje clínico los conceptos de escucha, sujeto y singularidad. **Conclusión:** el psicoanálisis puede guiar la práctica clínica, proporcionando la reflexión sobre cómo los sucesos vividos por el sujeto son significados en su singularidad; y cómo cada persona podrá significar su sufrimiento psíquico. La intervención es posible a través de la escucha del sujeto psicótico, en que sus producciones, sus escritos, sus documentos, sus invenciones, ayudándolo en el proceso de construcción de algo que pueda funcionar como soporte para que el sujeto pueda lidiar con su sufrimiento. **Descriptores:** Enfermería; Salud Mental; Psicosis; Psicoanálisis.

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INTRODUCTION

Psychosis is the manifestation of psychic distress that causes the emergence of a disintegrated person unable to cope with the real in confrontation with his psychic distress. In general, it is manifested by delusions and hallucinations. Unconscious ideas determine the operating mode in which the subject tries to modulate the external reality to his psychic reality. Thus, during delirium, the words are taken by things themselves. It is then, through the delusional construction, that the psychotic can articulate reality to his own psychic reality, making the second reality his own reality.¹

Traditionally in health services, psychosis is addressed through measures of physically restraining the subject associated with a pharmacological treatment. These actions are based on the biomedical referential that arose around the 18TH century, organized by the assumptions of modern science: scientific objectivity, generalization, and neutrality.¹

In this referential, the seizure of psychic suffering is limited to a mental illness that requires medication and rebinding measures between subject and the reality in which he is inserted. The diagnosis is formulated from a professional reasoning, by framing the subject in a nosological category, a disease situation, considering him incapable of dealing with his mental condition without these interventions.¹⁻² Another consequence of this model is the fact that the professional, being a doctor or a nurse, is located on the side of a predetermined knowledge that will be applied to the patient.²

A multiplicity of theoretical concepts exists to guide the nursing clinical practice in the same institutional space. The nurse takes the place of the knowledge holder in relation to the subject in psychic distress. This knowledge gives the nurse the authority to interpret and classify complaints from those subjects based on external and objectifying knowledge.²

The coexistence of different and sometimes contradictory conceptions subsidize the nursing clinical practice; practice that is configured as pedagogical, prescriptive, and normalizer of the subject in relation to health services.²

It is noticed that the biomedical model, when addressing the psychic suffering, excludes the subjectivity inherent in this condition. With respect to the psychotic subject, this model produces an approach that disqualifies this subject as someone who can engage and commit in the caregiving

relationship because he is devoid of reason. In addition, this model presents the physical restraint and pharmacological approaches as the only alternatives.³

Does this form of addressing the psychotic subject actually meet his unique care needs? How to care for this subject in a singular form, tending to his demands that are beyond the plane of rationality? Thus, we discuss the possibility of reworking the nursing clinical practice together with the psychotic patient based on the psychoanalytic referential. This research aims to understand the clinical approach of psychosis based on the psychoanalytic referential, performed by the nursing team.

It is assumed that psychoanalysis, by proposing the recognition of the divided subject and the subject of the unconscious, producing other ways to deal with the psychotic considering the uniqueness of each case, and rescuing the dimension of subjectivity of the patient from the act of listening. It also proposes to subvert the current position of the patient (object) by returning his position to that of the speaking subject.

Therefore, this study is relevant to contribute to the construction of new knowledge and practices for the nursing clinical practice in the approach of psychosis considering the psychoanalytic referential as a theoretical tool for the clinical practice.

METHOD

This was a theoretical essay based on psychoanalysis as a theoretical central referential that used as a source of research the complete works of Sigmund Freud, which address important elements of the clinic of psychosis, and some concepts proposed by Jacques Lacan, such as the subject Name-of-the-Father and exclusion.

RESULTS

♦ The transition of the nursing clinical paradigm in mental health

Nursing arises as a professional practice in the psychiatry field, and as the subsidiary knowledge in the medical practice. In the asylum assistential model, the nurses were responsible for guarding, punish, and control behaviors of subjects labeled as crazy.³ In this context, the scientific knowledge for the fundamental tasks of nursing were considered unnecessary. The goal of treatment was to eliminate symptoms that, in the case of psychosis, were characterized by delusions

and hallucinations. These manifestations were controlled through drug therapy and the pursuit of certain normative behaviors; through the social isolation caused by hospitalization.³

This model of organization of caring for the psychotic subject, later classified as mentally ill, was crystallized by the knowledge of biomedicine in a medical specialty, the psychiatry. — This process was driven by the development of knowledge in the fields of neuroscience and psychopharmacology.²

Historically, it is possible to identify disruptive movements in this paradigm through increasing concerns within the sociocultural, family, leisure, work, and housing contexts of the mentally ill. The disease was in question and the subject in its context of life was also seen as the problem.²

Psychiatry in Brazil went through a more effective process of change since 1987, from the National Anti-asylum Movement. This movement proposed a new assistential model and, among other assumptions, was based on assisting the mentally ill that outlast hospitalization as a first form of care. Since then, political initiatives engaged in drafting and discussing laws and governmental actions, seeking to create and ensure condign policies with respect and citizenship.³

The Brazilian psychiatric reform enabled the organization of a network of substitute services, the Centers of Psychosocial Attention (CPAS), and a reflection focused on the reconstruction of work process around the subject considered mentally ill.⁴ In this context, the very concept of mental patient has been rethought beyond the biomedical model; the focus has shifted from the illness to the subject, and from the body to the psychic.⁴ The psychic suffering, therefore, while a theoretical construct of mental health, is understood as

a subjective, social, and cultural process, and its dimensions not only affect the one who suffers but also those around him. It is a condition in which the person cannot interact with the objective reality of others, or become weakened and even question the meaning of life itself.^{5: 318}

The change in the assistential model had some advances with regard to restructuring the system with the organization of a network of care, from CPAS to in-patient services. This new setting brought mental health to the discussion space of health policy and practice. However, these arrangements alone do not ensure the change in the clinical practice for the subject in distress. Specifically in the nursing clinic, the practices driven by the

principles governing the hospitalocentric model coexist side by side with replacement-oriented practices, based on the psychosocial model of attention to health that emphasizes rehabilitation and social reintegration.²

This difficult transition paradigm for nursing stems from its own existential relationship with medicine, particularly with modern medicine. Having the biomedicine as the theoretical support leads to ways of dealing with the subject in psychic distress anchored in the concept of mental illness.^{3,5}

Prescriptive actions, without the opening of spaces for listening the complaints and anguish, and the reasons why the subject is seeking care, generate interventions that disregard the subjective dimension of the patient. For the psychotic subject, specifically, the attempt to adapt his behavior to a standard of pre-set normalcy excludes the opportunity of the listening and, consequently, the recognition of what is said between the lines in the subject's speech.

The thinking of a paradigmatic transition for the nursing clinic in the field of mental health assumes a rupture with the biomedical paradigm, which implies the search of other theoretical and ethical referentials to care for the subject in psychic distress. Thus, the psychoanalysis referential emerges as a possibility to define new meaning for the approach of this subject, singling out the caring in the demands that he elaborates as opposed to vertical and external interventions.

Psychoanalysis arises in the 19th century with a neurologist named Sigmund Freud; according to him, the unconscious appears as the delimitation of a knowledge not known by the patient, that rather invade him in the case of psychosis, in the plane of thoughts itself (hallucinations, delusions).⁶

In the article "The Unconscious", Freud theorized and elaborated the concept of the unconscious, considering its topological, dynamic, and economic aspects. The unconscious consists of pulsional representatives who seek to unload a psychic energy with constant intensity that, when even kept away from the plane of consciousness, obstinately aims to self-satisfaction.⁷

In order to get this satisfaction, the primary psychic process operates by condensations and displacements, observed from the effects that the unconscious produces on the subject, such as *lapsus linguae* (flawed acts, short-term memory loss, symptoms, dreams, jokes) -metaphorical productions of this unconscious that never

shuts up.⁸Based on this referential, the psychotic subject has a truth to state about his experiences, feelings of persecution, bodily changes, and feelings of depersonalization because such psychic manifestations are produced in an attempt to obtain a sense of existence.

Because this is a marginalized referential, somewhat by its direct confrontation with biomedicine, and by its fundamentals and concepts being little known in the nursing field, the following topic expands the understanding of the concept of psychosis in psychoanalysis.

♦ The psychosis from Freud to Lacan

Along the construction of the psychoanalytic theory, the psychosis aroused the investigative interest of Freud, by not presenting the same curable condition present in cases of neurosis; this observation became, therefore, something even stranger and generated questions for him.⁷

In 1894, Freud readdresses the concept of psychosis to designate the subject's unconscious reconstruction of a delusional or hallucinatory reality.⁷However, the concept of psychosis cannot be seized in the work of Freudian alone. In view of the extensive approach of the theme and the character of work in progress that can be found in the texts by Freud, a short presentation about the psychosis in three periods it is necessary.

In the first period, until mid-1915, Freudian texts discuss the psychosis still under the paradigmatic logic of neurosis. While hysteria was the structural model of neurosis, paranoia was the model for psychosis. Freud turns his analytical curiosity to paranoia, mainly, by believing that it could be a healing process for schizophrenia, through the possibility of communication with the psychotic subject through the construction of delusions.⁹ However, with regard to the clinic, Freud thought that the establishment of transfer with those psychotics having difficulty in establishing social bonds would be complicated, if not impossible. So much so that the only case on psychosis, drafted by Freud, dates from 1911 and is found in the text "Psychoanalytic Notes on an autobiographical account of a case of paranoia (*dementia paranoides*)". This is an analysis of the book of *Memoirs of someone sick in the nerves*, written by judge Schreber.⁶

Schreber contended the delirium of remission of humanity when he believed in his own transformation into a woman so he could submit to the act of copulation through the fertilization process directly with God. He

stated feeling his body dead and in decomposition, but that it was a divine order confirmed by voices that talked to him; he attempted suicide and thought of his own doctor as a stalker, a place later assumed by God.⁶

In the texts "About Narcissism" (1914) and "The Unconscious" (1915), Freud's discomfort in trying to explain the psychoses is noticeable, continuing to advance in the formulation of the defense mechanism of psychosis. In "About Narcissism", Freud makes a re-reading of the Schreber case, from the theory of narcissism, classifying the psychosis as a situation in which the subject directs all his libidinal investment to his own ego, leaving no space for alterity.¹ Based on these features, Freud was sure that the psychotic would not establish a relationship of transfer and thus, according to him, "they become inaccessible to the influence of psychoanalysis and cannot be cured by our efforts".^{10: 82}

In the article about the meta-psychological unconscious, Freud's goal was to clarify the conception of this obscure concept, using attempts at reconstructing and re-establishing narcissistic psychoses.¹

In the latter part of this article, Freud establishes relations between the unconscious and psychotic formations, through the observation of the schizophrenic speech. According to him,

We observed this in schizophrenics - especially in the early stages, so instructive - great number of speech modifications, some of which deserve to be considered from a particular point of view. Often, the patient devotes special care to the way of expressing himself, that it becomes 'affected' and 'precious'. The construction of his sentences undergoes a peculiar disorganization, which makes them incomprehensible to us, to the point that they sound disparate.^{11: 202}

To exemplify this theorization, Freud cites the example of a patient, treated by a medical colleague, who sought analysis after several discussions with her lover because she considered him a hypocrite, and began to see the world with different eyes. So for her, he was an eye bender.¹²

According to the patient, her lover had bended her eyes. Freud characterizes this phenomenon as the speech of the organ, and assumes that there is an existence of a representation of things to the psychotic that features how to operate his unconscious. Therefore, a representation of words occur, which when linked to the representation of things allows us to be aware of our thinking. In the case of psychosis, a regression to an

unconscious mode of functioning occur, whose consequence is taking words as if they were things. Therefore, the psychotic subject does not produce metaphors in his language.¹²

In the second period, psychosis can be seized from a mechanism, called by Freud, of rejection or refusal resulting from the settlement of a conflict between self and reality. In the last texts of his work, Freud develops his studies about this conflict as being the subjective division, and it is through the concept of castration that this division is better understood.¹²

The symbolic experience of castration is understood as a response to the subjective division that can lead to two conflicting positions. In the text "Outline of psychoanalysis", Freud illustrates this question well: the first object of satisfaction in the one who comes into the world, the baby, is the being/person who performs the act of taking care of him, his mother.¹²

The mother is the one who beyond her functions of breastfeeding introduces an entire symbolic order when awakening in the body of the baby other pleasant and unpleasant physical sensations. At this point, the baby does not distinguish the *gestalt*, i.e., him, the mother, and the mother's breast are all one thing.¹² However, the mother is perceived as presence/absence when the child notes that he is not, imaginarily, the only object of desire of the mother. It is at this point that the openness to life occurs, the prohibition of incest, and thus castration. Thus, Freud elaborated that the rejection of castration, of mother/infant separation, would structure the subject as psychotic.¹²

From the theoretical point of view, Freud explored exhaustively every possibility to explain the psychotic structure; however, it would not be an exaggeration to say that the Freudian clinic failed to fully explain psychosis. Nevertheless, despite of not having treated psychosis cases, Freud left a great contribution with the analysis of the Schreber case and paved the way for other contributions.⁹

On the third historic period of the psychosis approach by psychoanalysis, we can find the contributions of the French psychoanalyst Jacques Lacan. He started from the study of psychosis in his doctoral thesis and entered the studies in psychoanalysis.⁹

In early 1950, Lacan made a resumption to the Freudian theoretical construction and established his position in psychoanalysis, he articulated the founding mechanism of psychosis linked to a significant operation or, in other words, to a symbolic operation that

occurs at the level of language.¹¹ From this operation he could make the proposition that the unconscious is structured like a language, and substantiate the clinic of psychoses.

The Lacanian theory brings the concept that the symbolic field is set prior to the subject's birth, because even before birth it already exists in the wishes of parents, who plan his life, give him a name, and define him through significant ones (those who establish meanings).¹³ Therefore, every subject is born alienated to the Other (A) of language, a place of the treasures of meanings. Returning to Freud, the place of the Other is initially occupied by the mother, by the strange language of the mother's language, which can respond with the significant ones from all, from the subject of mythical sheer necessity - the baby. This is the symbolic resource to represent hunger, thirst, and other experiences to come.¹³

Lacan, with his discovery of the unconscious as this place of the Other, allowed the finding of a place where the subject realizes his subjective division by being the subject of the wishes of the parental Other. From the moment that this mother has other desires (the husband, work, and other children) she is perceived by the baby as presence/absence, therefore, the baby realizes that he is not, imaginarily, the only object of desire of the mother. At the moment the baby perceives the mother as a lack-to-be.⁴

To prevent the support to the incestuous desire in the mother and baby relationship, Lacan claims that there should be the inclusion of the Law: a symbolic father, maternal metaphor called The Name of the Father, which in French (Le Nom du Père) that through homophony sounds as the non-father.^{10,13} This metaphor is a significant structurer of all significant ones who constitute the Other's speech, whose function is to annul the mother-child unit and stop the impulse of abusive human satisfaction providing an assimilation on the part of the child of a new name (significant) that neutralizes the desire of the Other.¹³

With the maternal metaphor and the three times of Oedipus, Lacan resumes to the logic of Freudian castration: a symbolic act whose agent is a real person (parent/genitor) who cuts/strips the son from the imaginary object (the phallus), barring the subject's access to pleasure.¹³ Thus, Freud shows that the subject divides in front of castration and that this creates a rift that never closes, indicating that the division of the subject and the castration are incurable.

For Lacan, there are three forms of denial of knowledge about the truth of castration, which is expressed differently facing the specific form of relationship of each subject with the Other. This is what defines the psychic structure of the subject, and thus, the structural diagnosis in psychoanalysis: neurosis, psychosis, and perversion. While the neurosis is marked by repression, and perversion belies castration, in psychosis the subject excludes this process.¹³

In psychosis, the rejection on the part of the subject of the significant The Name-of-the-Father occurs. The exclusion of the significant happens before the denial established by the subject. For Lacan, this term represents an operation without enrollment of the significant in a timely fashion, making its function symbolically dead and dysfunctional as its effects.¹³

Therefore, the exclusion is characterized by the non-operation of the paternal metaphor and, thus, the Other is consistent, speaks, and tease the subject. By not being integrated into the unconscious, as in the repression, the significant returns in the form of hallucinations or delusions in the reality of the psychotic structured subject.^{11,13}

♦ Contributions from psychoanalysis to the nursing clinic for the psychotic subject

In this brief explanation about psychosis based on the psychoanalytic theory, other possibilities can be identified for the nursing practice in approaching the psychotic subject. Psychoanalysis offers tools for this approach such as the talking cure, the technique of free association, the floating attention, and the transference and listening relationship.

The effects of the talking cure can assure the psychotic subject a space to build another way to deal with his views of existence before the psychic suffering. Each subject constructs a chain of significant ones in his own way under the labels from his insertion in the language, so that the subject's psychotic speech reveals knowledge about himself.¹³ This occurs because every subject is a desiring subject, arisen from the effect of language, and thus unique and singular. However, this knowledge is hidden under his conscious speech, requiring from the professional nurse the hold of psychoanalytic tools such as listening, therapeutic relationship, free association of words, and the floating attention.⁷ This implies in dealing with the emptiness of the not-knowing about the anguishes of another during the process of therapeutic listening. Nevertheless, the

subject himself validates his own knowledge and not external interventions, aimed at resolving his problems, judging his feelings, and literally interpreting his speech.¹⁰

The nursing clinical practice cannot be based on the pursuit of objective causes of suffering. The movement needs to be instituted by both, allowing the subject to talk about what happens to him. Another tool that stands out for the psychotic subject is the technique of free association, which is the strategy to let the subject talk any content that arises in his thoughts.⁹ No matter what chronological time the subject speaks, in this technique the unconscious will be present at the discursive scene and the subject can reshape other significant ones in his distress, symptoms, or delusions.

The floating attention on the part of the listener implies in allowing his own unconscious activity to operate as freely as possible, suspending the motivations that usually drive attention.¹² Thus, before the psychotic subject's speech, one must identify its elements (themes, phrases, words, interjections), i.e., the significant ones in this speech. These operators go unnoticed when the nursing is guided by another referential and not psychoanalysis.

The professional must learn to intervene at the right moment of listening, causing the subject to not remain paralyzed in a specific point of his associations, but rather allow the subject to reconstitute the history of himself with the wefts of his suffering, giving up the position of owner of knowledge regarding the suffering of another.¹⁴

It is interesting that the nurse occupies a position of testimony in the construction of a meaning by the patient from the significant ones that permeate his speech and arise at different times; and in this position, it is also interesting to consider it irrelevant at first if this speech is delusional or not, because something about his own singular truth is in the delusional psychotic subject. This position of witness is called secretary of the alienated by Lacan.⁷

Considering this function and articulating the nursing care to the psychotic patient, nurses cannot reject the foolish sayings from the subjects; they are rather what is most valuable in their speech because they are singular.

If we know how to listen, the delirium of chronic hallucinatory psychosis manifests very specific relationships in the subject in relation to the set of language systems in its different orders. Only the patient can testify that with great energy.^{13: 237}

In interventions with psychotic patients, in order to act as the secretary of the alienated, the construction is treated with a substitution for the maternal metaphor during the transfer relationship. That is, if there is no significant Name-of-the-Father, the professional guided by psychoanalysis must act as the secretary to the subject in building something that has the strength to stop the overwhelming invasion force of the Other, which Lacan called the delusional psychotic's metaphor.¹³

Recalling the Schreber case cited in this study, the stabilization of the relationship between the significant and the signified did not occur because the patient did not have a secretary, who could have promoted the stabilization of the psychotic clinical condition.¹³ Thus, in the psychotic condition, the lack of the primordial significant, generates an unbearable anguish that triggers delusions, hallucinations, and outbreaks because this is the significant that ties up others in the significant chain, where unconscious slides.¹³

The psychotic's delusional associations act as a strategy of organizing his life, reestablishing the link with others, and as a spontaneous healing promoted by him and thus, through it, reestablishing social ties.

The delusional speeches indicate the presence of a life drive in search of a possible link between the sensory experiences and socially compatible codes. Thus, the delusions must be valued and respectfully listened to because they are the possibility of reconstruction of this subject.¹¹ Therefore, the importance of the one acting as the secretary for the alienated stands out. In this case, the nurse would work collecting the psychotic's speech and reconstructing a possible explanation about his existence. The interpretation of the repressed, as in neuroses, is not the purpose here, but rather it is for building a story that works as the Name-of-the-Father, i.e., that serves as a foundation for the 'I am' of the subject. However, for the nursing clinic to be conceived with this in mind, it is important to qualify the nurse's listening skills, enabling this professional to be able to listen to what the subject says about him because it is through language that this subject expresses his truth. Therefore, the treatment will be in the elucidation that the patient may promote upon himself. The nurse, fits in the place of a witness, or as Lacan designates, as the secretary of the alienated.¹¹

It is the responsibility of the nurse to develop a floating attention, identifying the errors that may occur in the speech of the

subject, and from these, explore the possibilities of new significations avoiding early interpretations so that the subject does not leave this place in the treatment. And thus, enable the psychotic to assert himself as a fellow holder of a discourse and a desire, putting himself in another subjective place that is no longer being the object of the Other's pleasure.

Therefore, it is through the word, and only the word, that the nurse can get situated in a point in the delusional speech of the patient and wait for the moment to help him to elaborate new meanings. From this perspective, the subject takes his own history, implying his own wishes and no longer only with the wishes of the Other.⁷

The purpose of the clinic is giving way to the subject through language, allowing him to appear and thus, identifying the subjective nexus that constitute him. To transcend a clinic that responds only to the conscious dimension, it is recommended that the approach to the subject be through the recognition of his uniqueness.¹³

To think of a nursing clinic through the psychoanalysis referential implies to let the subject consolidate the most appropriate therapy according to his uniqueness and then produce a truth about him taking responsibility for his choices.¹³

CONCLUSION

The clinical practice of nursing for the psychotic subject from the psychoanalytic referential can be drawn from the provisions of the talking cure, the technique of free association, the floating attention, the transference relationship, and listening.

In psychoanalysis, the nurse assumes the condition of the secretary of the alienated, i.e., the one who is willing to listen to the psychotic subject assisting him in the process of construction of a truth that can function as psychic support.

Although mental health services do not always provide the necessary conditions to develop listening, it is up to the professional to exercise inventiveness. In addition to the imperious opposition to conditions that limit the clinical nursing practice, it can be adapted to the possibilities presented by reality.

Moreover, it should be noted that the nurse should not fall in the risk of trying to make the subject go back to a previous state considered normal. The psychotic structuring is not a disease, but a way of the subject to constitute and defend himself in the world.

The delirium has its own role in the psychic organization of this subject. Therefore, the attempts to force 'normalization' on this subject can have effects more devastating than therapeutics; it is also necessary to invest so that the psychotic acquires a place of prominence in his treatment taking ownership of his history and suffering. It is important to give voice to the subject in relation to what refers to his therapeutic project by following his movements in his meeting with the team and avoiding challenging or shaping interventions based on prior knowledge that would situate him as a single object of care.

It is considered important that mental health settings include spaces for the discussion of clinical cases, favoring an interdisciplinary work and the follow-up of each case in clinical supervision because it is in these spaces that nurses can perform the exercise of reporting and talking about the case in order to even work from their own repression.

To take the professional attitude of clinical analyses in psychoanalysis entails ethical dimension and passes, first and foremost, through a desire based in the following tripod: theoretical study, clinical supervision, and personal analysis. Therefore, this is something that is built on the unique experience, and that everyone who is interested in learning this path would go through it in their own way.

The clinic nursing practice with the psychotic patient guided by psychoanalysis is a bet on the dialogue with other knowledge areas on the possibility of making another speech in the spaces where, sometimes, it seems that only the biomedical vision is possible. Certainly, concerns and questions will arise. What happens from here on is on each one take because the proposal of reflection has already been presented.

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