

# Psychiatry's clinical tradition, psychoanalysis and current practices in mental health

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**Abstract:** The paper analyzes the clinic of psychosis in the mental health field by revisiting classical psychiatry categories through psychoanalysis, especially mental automatism. This paper aims to demonstrate the usefulness of what may be considered a working plan for the clinic of psychosis, which is today polarized into biological reductionism and psychosocial care. The accuracy of these classical psychiatric descriptions, revisited through Lacan's theory, enables the recognition of the complexity of psychosis and especially the subject's efforts to tackle the difficulties that result from this condition. In the conclusion, we analyze Clérambault's syndrome called "mental automatism" so as to demonstrate every subject's structural dependency on language and on the signifier, from which the subjectivity as an effect is derived.

**Keywords:** psychoanalysis, psychosis, psychiatry, mental automatism.

## Introduction

This paper discusses the clinic of psychosis by establishing a relationship between psychoanalysis and psychiatry in the mental health field, tackling mental automatism syndrome established by G. G. de Clérambault in the early 20th century, and highlighting the importance of a later approach to other clinical descriptions produced by classical psychiatry. This approach was initially made using the first author's work within Niterói's health care system (with the especial aid of the Workshop on Psychoanalysis that took place in Jurujuba Psychiatric Hospital, with Eduardo de Carvalho Rocha and Francisco Leonel Fernandes) and subsequently developed with the other two authors in the Psychoanalytic Theory graduate program at the Federal University of Rio de Janeiro. It is also a result of the work on psychosis carried out at the *Tempo Freudiano Associação Psicanalítica*, including discussions with professionals from Sainte Anne's Hospital School of Psychoanalysis, in Paris. These discussions were conducted by studying texts produced there, which led to five meetings in Rio de Janeiro and Paris between 2003 and 2012.

What drives us is the certainty that, although the psychiatric reform has been rightly implemented for the political dimension of citizenship and social inclusion of the insane, the treatment of severe mental disorders in the mental health field does not ignore psychiatry and psychoanalysis tradition. This is the purpose of the contribution that, together with other authors, was designed to give rise to debate regarding psychosis clinical-institutional treatment.

Different initiatives from different clinical schools of thought have sought to defend the relevance

of psychopathology studies in the mental health field in Brazil: the so-called "fundamental psychopathology" (Berlinck, 2008); the proposal of a "psychopathology of common-sense" or psychopathology of "being-in-the-world", based on Husserl's phenomenology and Heidegger's philosophy, and revisiting the works of Jaspers, Minkowski and Binswanger (Leal, 2006; Serpa Jr., 2006); the attempt to make the 'construction of the clinical case' a reference for mental health services, based on Lacan's concepts (Fong, 2004); and, within psychiatric knowledge, referring to researchers who suggest revisiting psychiatry's psychopathological tradition, which has been replaced by DSM's descriptive and statistical approach (Aguiar, 2004; Banzato, 2004; Lima, 2012; Pereira, 1996).

Our intent was to work within a predetermined focus: revisit through psychoanalysis clinical descriptions of classical psychiatry. We followed Lacan's indications (1954-1955/1995, p. 299; 1955-1956/1992a, p. 33; 1958/1998a, p. 69; 1960-1961/1992b, p. 106) and contemporary works that aroused our interest for this study program and that guided us (Czermak, 1991, 2009, 2012; Ferretto, 2009; Sciarra, 2005; Tyszler, 2011).

The hypothesis that guides these studies is that, within the rich nosological descriptions that characterized the French Clinical tradition, which were highly valued by Lacan (1955-1956/1992a), there is a clinical reference to find what is related to the subject in every psychosis – the subject's relationship with language that makes him a subject, and the subject's work that may exist there. Despite the organicist assumptions that characterized these approaches, clinical descriptions and the way they were transmitted in the texts may represent today, in light of Lacan's structural approach, a prolific clinic reference for us to identify the subject's functioning that is constrained and hindered by psychosis.

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This study's practical and theoretical field is triply determined: by the psychoanalytic theory of psychosis, by psychiatric tradition and by current approaches to psychosis in social and technical-specialized environments – on the one hand, psychiatry that leans towards biological reductionism to explain psychopathological phenomena, and on the other hand, communitarian practices of psychosocial care. Today, the debate over the treatment of psychosis is polarized between biological reductionism, causing effects of suppression of the subject, and psychosocial care, which aims to promote the psychotic's life in society, leading the subject closer to social rehabilitation. We have argued that this polarization excludes the unique consideration regarding every psychotic patient's path, as both therapies are based on universally established goals in their functions: remission of symptoms and restoration of mental functions, regarding biological reductionism in psychiatry; and a better functioning and insertion into social life, regarding psychosocial care, with universal goals and therapeutic parameters such as greater personal autonomy, not being admitted to a psychiatric hospital for treatment, work or earning an income somehow etc.

In this sense, these two divergent trends inadvertently converge on the approach to give the subject a better social functioning.

Following Lacan and the aforementioned authors' indications, we revisited psychiatric descriptions from the late 19th and early 20th centuries so as to find a structural reading of psychosis. We aimed at accomplishing what might be called a psychoanalytic recovering of psychiatric entities – certain that this is a possibility for advancing the theory and the clinic of psychosis in psychoanalysis, psychiatry and mental health.

## **Psychoanalysis and psychiatry – a work program**

Current psychiatric classifications (American Psychiatric Association, 2013; Organização Mundial de Saúde, 1993) abolished the basic categories which were related to psychoanalysis – neurosis and psychosis – and replaced them with a proliferation of descriptive and supposedly 'non-theoretical' categories, grouped by common themes or descriptive similarities (anxiety, mood, food and stress disorders, among others). This led to the medicalization of disorders previously associated with the subjectivity (neurosis), which demanded no more on culture for a psychotherapeutic process of subjective elaboration in favor of a demand for pragmatic resolution of symptoms using drug therapy (Russo & Venâncio, 2006). As for psychosis, the adjective 'psychotic' remained to designate the manifest occurrence of hallucinations and delusions, taken as indicators of a loss of the sense of reality (Organização Mundial de Saúde, 1993, p. 3). Schizophrenia became the only clearly recognized condition as being psychotic, approached by the global deficit in functions – affection, pragmatism, internal consistency of mental processes, use of intellect etc. – and inclined thus to be associated with a biological deficit.

Psychosis was no longer conceived of as a fundamental category in the third revision of the Diagnostic and Statistical Manual of Mental Disorders, DSM-III (American Psychiatric Association, 1989) nor in the International Classification of Diseases (Organização Mundial de Saúde, 1993), and remains so until the present day. Although, according to the current classifications, diagnosing schizophrenia is based on a coarse disorganization of psychological functioning or on the presence of pronounced and persistent negative symptoms, what we observe in mental health institutions is an ever-increasing difficulty to recognize a psychotic functioning in the absence of hallucinations and delusions. One of the effects of such difficulty of recognizing psychosis is the increase in the diagnosis of "personality disorder". DSM-III suggested that certain cases previously classified as psychotic, but that did not present delusions and hallucinations should "possibly" be diagnosed as personality disorders (American Psychiatric Association, 1989, p. 199). Therefore, psychotic cases without the so-called productive symptoms has thus been referred to as 'personality disorders'. As for the former manic-depressive psychosis, it reduced 'psychosis' to the accessory presence of hallucinations and delusions (bipolar disorders are only recognized as psychotic in the presence of these symptoms). The diagnosis of schizophrenia started to include all "atypical" psychoses, becoming a kind of "unique psychosis" (Rancher, Rondepierre, Viillard, & Zimbra, 1993, p. 14). One might assert that, since Bleuler (1911/1993), there has been an encompassing expansion of schizophrenia over other psychotic disorders that were once distinguished by their specificities. This resulted in a reduction in the concept of psychosis to a deficient condition, characterized by loss of functions and deteriorating development. Psychosis was no longer considered a subject's specific mode of functioning (Rocha & Fernandes, 2004; Rocha & Tenório, 2004).

Both Freud (1911/1995) and Lacan (1955-1956/1992a) had reservations regarding schizophrenia and preferred to tackle psychosis through paranoia: "What seems more essential to me is that paranoia should be maintained as an independent clinical type, although, frequently the picture it offers may be complicated by the presence of schizophrenic features." (Freud, 1911/1995, p. 70). According to Sciarra (2005), Freud tackled psychosis through paranoia because the paranoid subject verbalizes the themes that organize a subject – the relationship with the other and with the object, with sex, with passion, with reason – and because in it the transference phenomena are more evident. According to Freud's hypothesis, paranoia reveals the subject's work through the delusions. Lacan (1932/1987, 1955-1956/1992a) treads the same path and says that Freud "draws a dividing line" between paranoia and schizophrenia. What is at stake is the distinction between deficit and structure:

for Freud, the field of psychoses is divided into two. What does the term psychosis cover in the field of psychiatry? Psychosis is not dementia. Psychoses,

if you like – there is no reason to deny oneself the luxury of this word – correspond to what have always been called and that legitimately continues to be called insanity. This is the domain that Freud divides in two. (Lacan, 1955-1956/2008, p. 12)

Psychosis is insanity, and Lacan (1955-1956/1992a) adds: “nobody goes insane through wanting to” (p. 24). Psychosis and neurosis are structures that subject the individual to their constraints and that function according to their own logic.

The emphasis given to the deficiency in schizophrenia is criticized, usually supposed to be a biological determinant (Tyzler, 2011, p. 88, our translation), and so is the fact that “more important semiological references” and “more accurate descriptions of different clinical types of psychoses” are relegated to forgetfulness (Sciara, 2005, p. 42, our translation). This does not mean that it has been ignored by Freud, Lacan or lacanian psychoanalysts, as demonstrated in Brazil with the texts organized by Alberti (1999) and the work of Quinet (2006). This diagnosis meaning in mental health work makes clinical pictures to be tackled by schizophrenia, which would have their specificity better enlightened by other references from the psychiatric tradition.

If the German tradition, which created the concept of schizophrenia, is known for its major categories, the French tradition identifies discrete elements in the mathematical sense of the term, referring it to different and discontinuous units that do not form a whole, and in the linguistic sense of the term, referring it to the element that articulates with other elements of a given structure without, however, losing its individuality. Therefore, the French tradition produced descriptions of clinical developments, which do not replace the diagnosis of schizophrenia in the classification, but enlighten and break down the elements and main forces at work there. These descriptions retrieved by Lacan have contributed to a structural approach to schizophrenia.

We have thusly sought in our research to retrieve the clinical pictures that remained in the shadow of schizophrenia and that only a certain French Lacanian psychiatrist insists on standing by. These are:

Clérambault’s mental automatism (1924/2009a), which we will discuss in the next section of this paper.

Hypochondria as a “broader concept in the clinical field of psychoses, since none of them escape hypochondriac phenomena” (Sciara & Brillaud, 2006, our translation). Phenomena of the body are characteristic of schizophrenia, because language fails to symbolically organize the body’s experience. “The so-called schizophrenic,” says Lacan (1973/2003) specifies itself precisely for “being caught without the aid of any established speech” (p. 475, our translation).

Cotard’s syndrome or the delirium of negation consists of the delusional belief that one does not have his/her internal organs, he/she is not alive, and therefore is

condemned to immortality as an endless suffering (Cotard, 1880/2006). It is a melancholic delirium and its fundamental features may be present in other types of psychosis, demonstrating the existence of common structures in the different types (Czermak, 1991) and indicating a period of severity and risk in their evolution.

The classical concept of transsexualism as a mental illness, but different from perversions (Castel, 2001), carved the path for detecting the dimension of delirium and attributing it to psychosis (Czermak, 2012; Frignet, 2002). Just as is true with delirium, transsexualism enlightens the trend towards ‘feminization’, identified by Lacan (1958/1998a) as structural in male psychosis and whose first example is the famous Schreber case examined by Freud (1911/1995).

The so-called Syndromes (or disorders) of recognition. In the syndrome of illusion of doubles or Capgras’ syndrome (Capgras & Reboul-Lachaux, 1923/2006), the patient believes that the person with whom he or she lives with has been replaced by a double. In the Fregoli delusion (Courbon & Fail, 1927/2006), the different people that the patient meets are always the same person (the persecutor), disguised or embodied in whoever is in front of the patient. These are phenomena that we found in the contemporary clinic of schizophrenia and for which we do not have an appropriate vocabulary for its specificity – the disjunction of structural elements that in the neurotic seems to be naturally associated: the name, the image and the object (Thibierge, 2011).

Finally, erotomania (Clérambault, 1920-1923/2002). In its pure form, this delusion of being loved is considered a type of paranoia. We find less organized occurrences in schizophrenia, but which are no less grave and experienced as invasive. Knowledge regarding this syndrome and the probability of its occurrence during any psychosis is quite useful so that the clinical psychologist can manage psychotic patients’ vulnerability to transfers (Czermak, 2012), including situations in institutions and the community.

Our assumption is that these psychiatric pictures are modalities according to which the subject reacts to the incidence of language and that its approach using psychoanalysis allows the identification of the subject’s work to rearrange his own experience. The psychoanalytic (structural) recovering of these references is a work program for us, which we started to explore through Clérambault’s mental automatism (1920/1998). We will not be able to tackle, in the scope of this paper, other aforementioned conditions, which should, however, be the object of future research.

## **Mental automatism enlightens our dependence on language**

Over the early decades of the 20th century, French psychiatrist Gaëtan Gatian de Clérambault described a clinical phenomenon that had not until then been isolated by alienists: Clérambault (1920/1998) affirmed it had not possible

in delusional and hallucinatory psychosis to recognize an initial moment that is characterized solely by mental activity experienced by the subject as estrangement and xenopathy. It detaches itself from the subject and becomes unfamiliar to him. A patient “perceives it as his/hers but as exogenous, the inner voice;” she suffers from an “automatic ideation” (p. 458, our translation). Others mention a thought or an automatic discourse that is entirely foreign. The novelty is that this is not an auditory phenomenon (hallucinatory). It is not often experienced as hostile or persecutory, and it is translated by affections as neutral. Clérambault differentiates these phenomena from hallucinations, delirium and any specific affective content, articulating them as an elementary syndrome of all psychosis. Lacan (1955-1956/1992a, p. 285) will recognize the isolation of the subject's relationship with language in this description, from which many affections constituting the subject's *pathos* (neurotic or psychotic) are a consequence.

It is the emancipation of thought and functions associated with it, e.g., speech, unfolding memories, false recognition, enunciation of acts, verbal impulsion, tendency towards psycho-motor phenomena, among others. They are neutral phenomena: “consisting only in the duplication of thought;” they have a non-sensorial nature: “the thought that becomes foreign does so in the usual way of thought, . . . and not in a defined sensorial way;” and they have an initial role in psychosis: they are “the first signs of psychosis” (Clérambault, 1924/2009a, p. 218, our translation). Hallucinations are “delayed” compared to them. And “delirium itself is nothing but a necessary reaction of a rational mind” to this phenomenon (Clérambault, 1920/1998, p. 459, our translation), since the experience of feeling the thought is blocked, commented, anticipated, heard as an echo, becoming someone else's thought, tends to lead to the certainty of being controlled, robbed, influenced – in short, to delusions of influence and persecution. Clérambault (1924/2009a) insists on emphasizing the initial and neutral nature of the phenomenon: “I set these phenomena against auditory hallucinations, i.e., voices that are objectified, individualized and thematic all at the same time” (p. 217); and “it does not admit any delusion to itself” (p. 218, our translation).

What we conclude from the precision with which the psychiatrist restricts the phenomenon to the “mind” and to the functioning of “abstracts” – not being a sense-perception phenomenon, or an intellectual, or affective one – mental automatism is a purer phenomenon of the emancipation from the chain of signifiers. Without using the term, Clérambault isolates the functioning of the signifier in the subject. Regarding this matter, Lacan (1955-1956/1992a) considers that mental automatism has the doctrinal value of indicating the exteriority of the chain of signifiers regarding the subject.

[Clérambault's] weak etiological or pathogenic deduction has little importance for us compared to what he values, namely, the necessity of reuniting the core of

psychosis to the subject's relationship with the signifier in its more formal aspect, in its aspect of a pure signifier, and everything built around there are just affectionate reactions to the first phenomenon, the relationship with the signifier (pp. 284-285, our translation).

The scope of this remark is not restricted to psychosis. Even for the neurotic, language also operates by itself and imposes itself in its functioning. The mechanism for anticipation-feedback characterizing each speech act – is not different: when a sentence begins, the speaker and listener are compelled to anticipate what will follow. For every word said, the next word or end of the sentence is imagined. Inversely, when a sentence is finished, a feedback is made based on what has been said to determine or confirm its meaning. The feedback never produces a complete identity together with what has been anticipated, but for the neurotic this discrepancy is not xenopathically experienced, the subject does not feel that it was not him who said it. He may experience anguish, surprise himself, but he will assume in the field of the subject this functioning of language that occurred in him.

This procedure is automatic for the neurotic without realizing it. The functioning of language, even if external to the subject, produces a ‘subject’ effect. For the psychotic, this exteriority of language is felt by him as an effect of exclusion of the subject. For him, language operations that characterize the functioning of the mind do not provide him a place, they exclude him/her instead, objectifying him/her because of these operations.

Let us consider examples from Clérambault's work (1924/2009b): “My memories are shown,” says the patient (p. 228). Well, whenever an event evokes a memory, is it not ‘shown’ to us somehow? Our understanding, however, is ‘I remembered’. An effect of subjectivity is produced: my memories, ‘shown’ to me by the spontaneous functioning of my ‘mind’ (of language), confirm that I am a subject, situated by my history, by affections bound to that memory etc. Language is understood by a subjective interiority. But for Clérambault's psychotic there is an effect of exclusion. The operation of the signifier produces an excluded subject. Another example: “I am forced to recognize people” (p. 225). When we see someone we are acquainted with, we are compelled to recognize that person! We do not have the option of not recognizing the person, we are not masters of the operation of recognition and identification, which is a signifier's operation above all. It usually causes an effect on the subject, however, this is not what happened with the patient. On the contrary, it remains in a xenopathic exteriority regarding him/her, and his/her experience is of being the object of an automatic action imposed to him/her. Instead of being experienced in the field of the subject, it is experienced in the field of the object.

The usual unfolding of mental automatism is the syndrome of influence, on the path to delusion, and the delusional experience of paranoid schizophrenics is a “secondary delusional development” (Ey, Bernard & Brisset,

s/d, pp. 582-583). Likewise, pure “emancipation from abstracts” (thoughts, memories etc.) tends to take over the hallucination’s sensory character, which is usually auditory. Therefore, mental automatism is the core of hallucination, which becomes to be regarded also as a mental automatism. But Clérambault (1924/2009a) insisted on isolating and naming the pure phenomenon as automatism.

For Lacan (1955-1956/1992a, p. 285) Clérambault thus gave a description for the foremost fact of any subject: his dependence on the signifier. Due to his submission to clinical facts, but maybe also to his presenting a point of view devoid of any psychologism (Jesuino, 2009), Clérambault could describe language’s condition of exteriority regarding the subject and the subject’s structural object position regarding language.

Czermak (2012) proposes that “mental automatism has fundamentally a structure of exposure” (p. 232, our translation). “Exposure of the subject to the Other,” explains Ferretto (2009, p. 124), for the subject declares that his thoughts and eventually his acts are commented, anticipated, directed etc. It is also an exposure of the structure itself, through a breakdown of the elements of the structure that govern the subject. It exposes the subject’s condition as an object regarding the signifier. It is a sort of distinctive mark of psychosis that reveals the condition of the subject’s structure.

Besides psychosis, mental automatism enlightens the effects of language in the field of the subject, and demonstrating that language’s structure, for its inconsistency, demands an operation to be carried out so that a subject of desire can arise from this structure. The subject finds the “battery of the signifier,” says Lacan (1960/1998b), in the Other in a prior state, so to speak. But “the subject constitutes himself only by subtracting himself from it and by decompleting it essentially, such that he must, at one and the same time, count himself here and function only as a lack of here.” The subject constitutes himself by subtracting himself from language and at the same time counting himself there. “The Other, as a preliminary site of the pure subject of the signifier” is the seat of language’s code. But, so as to produce a message from the code, which the subject might assume as his own, it is necessary that the subject himself accept that the Other’s signifiers represent himself. Whereas the psychotic, Lacan says, is “the subject who does not ‘make do with’ this preliminary Other alone” (Lacan, 1960/1998b, p. 820). Therefore, there is a subject that ‘make do with’ the preliminary Other and adds something of his/her own, even if it is the acceptance that those signifiers represent himself, the acceptance that the message coming back from the Other is his/hers. And there is the subject who refuses to accept what comes from the Other as his/her own message – it remains as it ‘previously’ is, i.e., belonging to the Other, hence remaining exterior to the subject. Language belongs, since its origin, to the Other. The price and the action imposed on a subject is that he/she constitutes himself taking as his/hers the Other’s signifiers. This initial imposition is restored each time a subject’s place is concerned.

Referring to a patient who suffered from the occurrence of words and phrases that were imposed on her, Lacan (1975-1976/2007) asks: “How can we not all sense that the words on which we depend are in a way imposed on us?”. The experience of this psychotic, says Lacan, “indeed is why what is called a sick person sometimes goes further than what is called a healthy man.” Lacan also says: “The question is rather one of knowing why a normal man, one described as normal, is not aware that the word is a parasite? That the word is something applied. That the word is a form of cancer with which the human being is afflicted.” (Lacan, 1975-1976/2007, p. 92).

Lacan’s observation stresses our condition as objects regarding language. This gives rise to at least two questions: if, as Lacan affirms, this is how we are determined by language, what is necessary for a subject to arise from it, and not an objectified condition created by language, whether in the form of mental automatism, or voices heard in hallucinations, or the static and commanding signification of delirium? And regarding psychosis, what are the means to treat this condition in which it is put to extreme conditions, in which the subject appears witnessing its impossibility or at least the force that pushes him to collide with the object?

## Final considerations

At the opening of his *Écrits*, Lacan (1966/1998c) describes the path that led him to psychoanalysis. Surprisingly, he mentions Clérambault and Kraepelin as those who lead him to Freud:

I was sensitive to the hint of a promise. . . . Oddly enough, but necessarily, I believe I was thereby led to Freud. It was faithfulness to the symptom’s formal envelope, which is the true clinical trace for which I acquired a taste, that led me to the limit at which it swings back into creative effects.

At least regarding psychosis, Lacan did not distinguish psychoanalysis from psychiatry. Fidelity to the “symptom’s formal envelope” – it is worth mentioning, the rigorous clinical description that identifies the phenomenon’s lines of force – is the clinical trait that connects psychiatry with psychoanalysis.

What has guided our studies is the certainty that, in the face of current psychiatric classifications’ discursive impoverishment, revisiting classical psychiatry through psychoanalysis increases our possibility of following the subject’s work in each particular clinical case of psychosis, namely how he/she organizes his/her subjective existence. These descriptions may thus help us pursue the aspect of invention present in each patient to organize his/her experience and, at the same time, determine the limits imposed by the psychosis’ structure. This is why we have sought to establish a relationship between psychoanalysis and psychiatry in the field of mental health.

### Tradição clínica da psiquiatria, psicanálise e práticas atuais em saúde mental

**Resumo:** Este artigo aborda a clínica da psicose no campo da saúde mental propondo uma retomada de categorias da psiquiatria clássica pela psicanálise, especialmente o automatismo mental. Seu objetivo é demonstrar a utilidade do que pode ser considerado um programa de trabalho para o campo de tratamento da psicose na saúde mental, polarizado hoje entre o reducionismo biológico e a atenção psicossocial. A riqueza clínica dessas descrições psiquiátricas clássicas, em sua releitura pelo viés da teorização lacaniana, possibilita reconhecer o funcionamento complexo da psicose e, em particular, o trabalho do sujeito para fazer face às dificuldades impostas por essa condição. Como conclusão, o automatismo mental de Clérambault é analisado visando a demonstrar a dependência estrutural de todo sujeito em relação à linguagem e ao significante, fato primeiro do qual deriva a subjetividade como efeito.

**Palavras-chave:** psicanálise, psicose, psiquiatria, automatismo mental.

### Tradition clinique de la psychiatrie, psychanalyse et pratiques actuelles en santé mentale

**Résumé :** L'article discute la clinique de la psychose dans le domaine de la santé mentale proposant un repris par la psychanalyse des catégories de la psychiatrie classique tel que l'automatisme mental. Son objectif est de démontrer l'utilité de ce qu'on peut considérer un programme de travail pour le champ du traitement de la psychose dans la santé mentale, polarisé aujourd'hui entre le réductionnisme biologique et la réhabilitation psychosociale. La richesse clinique de ces descriptions psychiatriques classiques, repris par le biais de la théorie lacanienne, permet de reconnaître la complexité de la psychose et surtout le travail du sujet pour faire face aux difficultés imposées par cette condition. En conclusion, l'automatisme mentale de Clérambault est analysé pour démontrer la dépendance structurelle de tous les sujets par rapport au langage et au signifiant, fait premier duquel la subjectivité dérive comme un effet.

**Mots-clés:** psychanalyse, psychose, psychiatrie, automatisme mental.

### Tradición clínica de la psiquiatría, psicoanálisis y prácticas actuales en salud mental

**Resumen:** Este texto trata de la clínica de la psicosis y propone que se retomen, a través del psicoanálisis, las categorías de la psiquiatría clásica, principalmente el automatismo mental. El objetivo es demostrar la utilidad de este programa de trabajo para el tratamiento de la psicosis en los servicios de salud mental, hoy polarizado entre el reduccionismo biológico y la rehabilitación psicossocial. La riqueza clínica de tales descripciones clásicas, desde la teoría de Lacan, permite reconocer el funcionamiento complejo de la psicosis y el trabajo hecho por el sujeto para enfrentar las dificultades impuestas por esta condición. A modo de conclusión, se analiza el automatismo mental de Clérambault con el fin de demostrar la dependencia estructural de todo sujeto en cuanto al lenguaje y al significante, hecho que produce la subjetividad como efecto.

**Palabras clave:** psicoanálisis, psicosis, psiquiatría, automatismo mental.

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