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THE PSYCHOLOGICAL DUTY: AN EXPERIENCE IN PSYCHOANALYTIC PRACTICE

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Abstract: The article presents a data collection, from the reports of the psychological shift of the school clinic; between the semester of 2017/02 to 2019/02; 160 hours; 130 patients; 251 calls; the result shows that the demands were: mood disorders; neurotic, stress-related and somatoform disorders; personality and behavioral disorders; emotional and behavioral disorders that usually start in childhood and adolescence; in addition to a small incidence of other disorders. The discussion runs through the theory of Freud to Lacan, addressing important points: free association; the anguish experienced by the patients; preliminary interviews and diagnoses; and the unconscious and the symptoms. It is divided into three parts: what is the duty; what happened on duty; and supervision. Finally, it shows the possibility of using psychoanalytic tools outside the usual practice model in Freud's time, bringing a contribution to academic training.
Keywords: Psychological duty, psychoanalysis, clinic, psychology.

INTRODUCTION

"A rush, an urgency. And a horrible compulsion to immediately break up any beautiful relationship that has barely begun to happen. Destroy before it grows" (Abreu, 2002, p.141) – says the poet Caio Fernando de Abreu – and it has a lot to do with human relationships nowadays.

The world and its conflicts, since the world is a world, we are in a relationship that without friction there is no relationship. We are social beings and language itself disorganizes and denaturalizes the biological body. There are all kinds of listening demands that are often neglected by different sectors and health services, but in Psychology, there has never been a lack of space for them; listening to the suffering of the subject who spins his own web in the midst of so many words. As the poet Miguel Hernandez says: Hiker, there is no path to be followed.

If you make the path, when you walk" (1985, p. 33). And, as Freud says, in his text: ``*The beginning of the treatment*``, based on the Aesop's fable: "Walk!".

A path that is made by talking, a path that is full of labyrinths, comings and goings, a constant feeling of 'remaking'. As psychoanalyst Adela Stoppel de Gueller says in her book: *Vestígios do tempo*: "Each one will be able to say, at the end of the journey, if the work has followed a path that, although it returns, does not make it to the same starting point" (2005, p.22).

In this sense, when receiving the patient, at the beginning of the professional conduct of psychology, following in the footsteps of the Federal Council of Psychology (art.1, 2005) which governs the psychologist's responsibility to provide quality psychological services, in decent working conditions and appropriate to the nature of these services, using principles, knowledge and techniques known to be based on psychological science, ethics and professional legislation.

Thus, the shift takes place in its listening mode, making it possible to open new passages, the idea is that of a path, that of a process, of evolution; listening, on duty, is in *floating attention*; a concept introduced by Sigmund Freud in 1912: "it simply consists in not directing the repair to something specific and in keeping the same attention 'evenly suspended' in the face of everything that is heard" (p.125); constituting an integral part of what was initially exposed: a focal character in psychological emergencies and urgencies under the guidance of a supervising professor with psychoanalytic training.

In view of this, based on the needs met, the free association technique was used as a conjunctive instrument ; In : ``*The beginning of the treatment*``, text of 1913, Freud says

that the fundamental rule in psychoanalysis is the free association, that is: everything being considered, it does not matter the subject with which the treatment begins, whether the history of the patient's life, the history of his illness or childhood memories. But in any case, the patient must be allowed to speak, leaving the starting point to choose (the golden rule of Psychoanalysis, the free association, as its creator - Freud said) of ideas that, in his practice, are present by the analysand's free speech, in order to let him flow freely in his speech.

In these contributions in the psychoanalytic field, we have the free association of ideas together with fluctuating attention. "I start with the word that translates the event into image and inscribes itself as a vestige; in the evocation, I can awaken the trace and reanimate it as an image" – as Gueller says (2005, p.38).

With this 'background', the free association that we mention to this principle here is from the perspective of the patient telling us their stories, memories and memories: "just like a train passenger who tells someone next to him what he sees through the window ". A kind of *chimney-sweeping*, as Anna O., a patient of Josef Breuer and Sigmund Freud, says.

This subject, the patient, starts to use the word as a way of exposing his anxieties, complexes and human frailties. In this engagement of dialogue between two subjects, nothing is lost, everything is preserved, therefore, there is a cure for speech, the talking cure.

From this perspective, contemporary discussions of intervention in this practice must be highlighted. Among them, such as that of psychiatrist and psychoanalyst Antonio Quinet (2005), who tells us that the biggest issue in initial care is to disentangle the symptom that is addressed to the analyst, transforming it and re-elaborating the patient's own psychic issues: "Yeah, very often, transforming a simple speech, in a question, into an enigma for the subject". It could be said that it is placing the subject in a hysterical position vis-à-vis his symptom.

It is a moment when the subject himself has the opportunity to hear his speech; after all, speech by itself already produces otherness and, from now on, it will be underlined, punctuated, marked and mirrored in order to produce not only meanings, but also empty them of meanings, or a construction of meaning, to the point that an event that previously occurred today has new and other meanings in its life – giving new meaning to the moments experienced.

In this sense, the theoretical perspective of acting on the psychological duty, allows for greater professional development of the extensionist in the health area, given that he must be attentive to the patient's speech, so that, in this modality, the use of preliminary interviews (the Freudian preliminary phase corresponds to the Lacanian preliminary interviews; by rigorously putting them into practice, it is possible to carry out the differential diagnosis of clinical structures) based on the cases treated in the different experiences lived there. In order to meet the proposed objective stated initially, based on the practice and experience of the assisted cases, we will describe, based on a data survey, the psychological profile of the patients assisted there; and, in the future, to be able to develop and write a case study.

SCOPE OF RESEARCH

Regarding the research technique, this is characterized by being an indirect, quantitative-descriptive data collection, which consists of empirical investigations, aiming at the design or analysis of the main characteristics of a phenomenon, the evaluation of programs and/ or even

the isolation of main or key variables. The experience of the Project called Psychological Duty includes a refreshing experience both for extension trainees and for the user population of the Clinical School of Psychology service at FAESA, located in Greater Vitória-ES. The project is a partnership with the Institution's Extension Nucleus and the Psychology Clinic, composed of 8 interns on duty during the research period (three of them participated in the elaboration of the research, together with the supervising professor), supervised by the professor and professional of psychogy; the shift has a workload of 4 hours per week for one semester, there is a process of selection of interns (students from the 4th period are eligible) and in the following semester, a new selection begins; the survey refers to the period corresponding to the second half of 2017 until the second half of 2019, totaling 160 hours, a total of 130 patients attended, corresponding to a margin of 251 consultations at all ages.

The research was carried out slowly, little by little the data were being produced as the services were taking place and, in the following semesters, the project was repeated. It must be noted that - despite the norms of the Psychology clinic requiring the TCLE (read and signed, allowing the use of patient data for research and publication purposes), as well as the Service Provision Agreement - the research mentioned here was used only the numbers presented in the final reports of each semester, public data and presented to different sectors of the Institution, as well as presented to the local community in order to give a brief overview of the activities and social commitment of this Institution with the local population; therefore, such data were: sex, age and the assigned ICD-10, as shown in the report. Thus, preserving any other data or personal information from them, or if you want information from their records (not used). Therefore, the research is characterized by indirect data collection in order to produce epidemiological data on the service provided, a quantitative one. This fact exempts us from submitting to the Research Ethics Committee, pursuant to resolution No. 510 of April 7, 2016, namely: "III – research that uses information in the public domain"; and, "V - research with databases, whose information is aggregated, without the possibility of individual identification". After all, the Research Ethics Committee of the Associação Educacional de Vitória, located at Rodovia Serafim Derenzi, 3115 – São Pedro – CEP 29032-060, Vitória-ES, telephone 2122-4176, email: cep@faesa.br.

We divided the writing of the research on duty into three parts, respectively, entitled: what it is, in which we describe what the practice in question is about; what happened, namely, the data collected in the years of activity; and supervision, theoretical and practical learning in the face of care provided. So, I invite you to know the work to follow...

THE DUTY: WHAT IS IT?

Psychological duty in Brazil as a modality dates back to the 60s, becoming an integral part of professional psychologist training, configuring itself as a field of practice. Influenced by current theories - which guided the practice of guidance in the United States, initially guided by the person-centered approach developed by Carl Rogers - it offers a population that often faces difficulties in receiving psychological care (due to the huge queues that are formed as a result of the numerous demand for the service) an alternative care, configuring itself as an emergency care without a prior appointment (but, which can also happen through referrals and/or appointments) with the purpose of listening to the subject in your suffering.

The term psychoanalysis was created by Sigmund Freud in 1896, thus inaugurating a particular method of psychotherapy whose

speech by the patient gained notoriety, producing knowledge that escapes the scientific model of that time and, also, of the present times. In the text: ``*The heredity and etiology of neuroses*``, by Freud, he mentioned the term for the first time: "I owe my results to the use of a new method of psychoanalysis, to the exploratory process of Joseph Breuer, somewhat subtle, but impossible to substitute to such a point, it proved to be fertile the obscure ways of ideation of the unconscious" (Freud, 1896, p. 145).

It is a method that originated through Josef Breuer's cathartic method, which explores the unconscious, through the patient's speech and by the interpretation by the psychoanalyst. However, the hysterics taught Freud that one must not interpret, decipher what was said by the patients, thus giving rise to the clinic of listening.

In this reading, the analyst knows nothing about the other, who must let the analysand speak; because the unconscious is structured like a language; rather, another language; as a structure, the unconscious is governed by laws totally different from those obeyed by the conscience, therefore the sense of unconscious escapes conscious understandings and senses and their interpretations – stricto sensu – in a kind of wild psychology – mentioning Freud's text, *Wild Psychoanalysis*: "If knowledge about the unconscious were as important to the patient, as people without psychoanalytic experience imagine, listening to lectures or reading books would be enough to cure him" (Freud, 1910, p.237).

Continuing this reading, another important turning point for Freudian theory was the abandonment of the hypnotic method, the cathartic method, and thus giving rise to free association.

It is noteworthy that before that, Freud early showed interest that psychoanalysis could dialogue with other areas of knowledge, using it to explain the psychic functioning, mainly through philosophy, literature and mythology. From this perspective, he wished that psychoanalysis was not limited to the medical sciences and that it could find its place in the natural sciences. And, also, of course, not being one-book – "I fear the one-book psychotherapist" (Calligaris, 2004, p. 30).

However, he encountered much resistance from his colleagues in the Society's meetings that it could not be applied to other fields of knowledge; despite such resistance, by some authors, mainly the French school, who said that the psychoanalysis called applied had caused psychoanalysis to lose its legitimacy as a science; another reason was given by Lacan - years later - in his critical review of Jean Delay's book whose title é: *La jeunesse d´ André Gide.* According to Lacan "psychoanalysis is only applied in the proper sense, as a treatment, and, therefore, to a subject who speaks and listens" (Lacan, 1998, p.758).

Despite the numerous contrary crossings, other authors supported and encouraged the initiative, Freud believed that psychoanalysis was a total science and that he would like to see it applied to other areas: "...to the solution of problems in art, philosophy and religion " (Freud, 1919[1918], p.188).

Therefore, the reflection that arises here is the importance of legitimizing the practice of psychoanalysis applied to the psychological duty, considering that, during the service, there is a person who talks and another guy who listens. Although there is a bias in which the subject who seeks the on-call service can be seen once, the practice of on-call at the Clínica Escola de Psicologia (in question here) can occur in up to four appointments, so that the subject, later, is referred to one of the psychotherapeutic approaches and services necessary internally or externally, as required by the case.

This handling through the on-call allows the subject who arrives in suffering the feeling of relief; an outlet for unease, a confrontation of their own issues, after all: ""falling ill avoided the task of solving it in real life" (Quinet, 2005, p.32); it also allows the physician on duty/ psychoanalyst to identify the possible causes of their suffering, we will then resemble the concept of preliminary interviews: "they have their diagnostic, symptom and transference functions. They correspond to what Freud called rehearsal treatment" (Quinet, 2005, p.11).

The analyst accepts the patient for a short period of time for one or two weeks, in order to establish a differential diagnosis, one of which aims to locate the subject. – trial treatment, in Freudian terms - within the clinical structures, neurosis, perversion and psychosis, from the three types of denial against the Oedipus Complex, guiding the course of analysis and, if there is interruption in the meantime, the subject will be spared a failed cure attempt. Such an expression will later be used by Lacan as preliminary interviews; eand that, in the words of Antonio Quinet:

[...] This expression indicates that there is a threshold, an entry point into the analysis that is totally different from the entry point into the analyst's office. It is a time of work prior to the analysis itself, whose entry is conceived not as a continuity, but — as the very name essay treatment seems to suggest — as a discontinuity, a cut in relation to what was previous and preliminary. This cut corresponds to crossing the threshold of preliminaries to enter the analytic discourse. This preamble to all psychoanalysis is erected by Lacan as an absolute condition: "there is no entry into analysis without preliminary interviews (2009, p.14).

During this period of time, the analyst allows the patient to speak most of the time, only making scores so that he continues to speak, that is, the analyst's role is to relaunch the subject to speak through free association – it marks the beginning, the starting point.

THE DUTY: WHAT HAPPENED

With regard to the collection of data from clinical practice in the institutional context of psychological duty - in this article - we consider the psychoanalytic method as essential, which gives voice to the individual who initially arrives in pieces. And, psychologically organized or disorganized, many patients were seen and that, by itself, generates a quantity of consultations.

In this sample follow-up, we inserted Table 1 in order to exemplify the production of listening in numbers of assistance provided, as shown in the final reports delivered to the Teaching Institution – Faesa at the end of each semester/period of the Duty. See Table 1:

The idea here, in addition to the stories heard, remembered memories, dreams and failed acts produced, was to be able to measure the population served and referred in order to know the demand beyond the psychic structures of psychoanalysis, but also from the diagnostic hypothesis as per the International Classification of Diseases – ICD-10.

Epidemiological data show that the demands were: mood disorders (depressive episode); neurotic, stress-related, and somatoform disorders (especially anxiety disorders); personality and behavior disorders; emotional and behavioral disorders usually starting in childhood and adolescence; in addition to a small incidence of other disorders.

The ICD-10 that were tabulated are clinical pictures consistent with the current ways of life, effects of the subjects' relationships in their daily lives - as Antonio Quinet says: "the symptom is smoke and fire is the subject" (2003, p.119) - sometimes with an excess of past (depression), sometimes with an excess

Year: 2017/2 - CID-10		
Age	**Male**	**Female**
0-15 years	F.93.0; F.98.8;	F.43.2; F.51.4; F.92.8; F.93.0; F.98.8;
16-29 years	F.41.0;	F.12; F.32.1; F.41.1; F.41.2; F.70;
30-45 years	F.41.2;	F.34.0;
46-60 years	-	-
> 60 years	-	-
Year: 2018/1 - CID-10		
Age	**Male**	**Female**
0-15 years	F.810; F.90.0; 91.3	F.82; F.98.8; X78;
16-29 years	F.60.0;	F.51.0; X.61;
30-45 years	F.60.3;	X.70;
46-60 years	-	F.33.0;
> 60 years	-	F.32.1;
Year: 2018/2 - CID-10		
Age	**Male**	**Female**
0-15 years	F.93.2; Q.02;	-
16-29 years	X.60	F.41.1; F.41.2;
30-45 years	F.41.2	-
46-60 years	F.32.0	-
> 60 years	-	
Year: 2019/1 - CID-10		
Age	**Male**	**Female**
0-15 years	F.80.0; F.93.0; Q.02; X.60;	F.50.8; F.93.0; Y.28;
16-29 years	X.60	F.41.2; F.43.1; F.50.8; Y.28;
30-45 years	F.41.1	F.41.1; F.43.1
46-60 years	F.41.2	F.43.1
> 60 years	F.32.1	-
Year: 2019/2 - CID-10		
Age	**Male**	**Female**
0-15 years	F.41.1; F.91.3;	F.91.0
16-29 years	F.43.2; F.60.3;	F.32.1; F.33.1; F.41.1; F.41.2; F.43.0; F.60.3;
30-45 years	F.41.1; F60.3;	F.41.1; F.43.0;
46-60 years	F.41.2; 43.2	-
> 60 years	-	-

Table 1. Epidemiological Data from the Psychological Duty

Source: FAESA's Applied Psychology Service – From 2017/2 to 2019/2

of future (anxiety); a society that neither tolerates nor gives time to work out the loss; in addition to causing anguish over time - to carpe diem - to the slogan time is money. Of course, the flow of assistance demonstrates that there is a portion of the population that is not going through there, namely: psychosis and drug addiction – there was no record. So, they are using other services available in society. Furthermore, there is no significant discrepancy or difference between the ICD-10 and the genders of the patients seen – as shown in Table 1.

It is inferred from the population assisted and we recognize beforehand, that one has to look into the language field of these assisted patients for a legitimacy and rise of the anguish in face of their symptoms. "Anxiety is an affection, an affection that is not repressed, it is untied, it goes adrift. We find it displaced, mad, inverted, metabolized but not repressed. What is repressed are the signifiers that bind it" (Lacan, 1962-1963, p. 22). Evidencing, above all, the aspect of formation of the unconscious and the fulfillment of desire. After all, "the discovery of the unconscious passes through the symptom" – Quinet guarantees (2003, p.117). The subjects arrive in anguish, suffocated with their symptoms, full of doubts and with 'loose affections' in their bodies, "where there is a symptom, there is the subject" (Quinet, 2003, p. 19).

From it, anguish constitutes a network of omnipresent signifiers in everyday relationships. We recall that, for Lacan, anguish is articulated with the Other's desire and the object a as a cause of not-knowing, a sign of the real placed at the center of the signifier, exemplified by the metaphor of the praying mantis; see the following theorization:

(...) the articulation point of the two floors of the graph, insofar as they structure the relationship between the subject and the signifier, which, it seems to me, must be the key to what Freudian doctrine introduces about subjectivity: Che vuoi?, What do you want? (...) The question is suspended between two floors, and precisely between two return routes that designate the characteristic effect in each one. (...) It is in the game of dialectics that binds these two stages so closely that we will see the anguish function introduced (2006, p.12).

In the extension of the services, we emphasize the importance of the duty in countless cases attended; among them, we present the strength they can have, in particular, with the example of teenagers who were in care who, by changing the traits inscribed by the original repression and experimenting with new effects on their position that they can occupy, re-inscribed the self-relationship facing the I-world relationship – a "subjective rectification" (Quinet, 2005, p.32).

This way, it is necessary to emphasize the analyst's position in relation to the analysand's discourse on how they build their stories in this I-world relationship. Freud, in his writings, configures two concepts that go against the services provided, namely: the manifest and the latent discourse; that, in these expressions of thoughts, there is the dream that is called in the scientific interpretation, the fulfillment of the wish. However, it deforms or transforms into something that escapes the conscious order, being the: "real road that leads to the unconscious, but not only that but also the point of articulation between the normal and the pathological." (Freud, 1900, p. 67). In this instrument that reveals the unconscious, the dream, we highlight a constituent part of the main foundations of psychoanalytic theory, since (between) the normal and the pathological is superimposed by the unconscious. "There is a pathos as the subject's suffering, since he suffers from the structure of language" (Quinet, 2003, p. 120).

In our treatment, in psychoanalytic practice, as a support point for all development, an allusion must be made to an introductory passage by Jorge Forbes (of this unconscious and its responsibility in the life of the patient undergoing treatment), namely: "[. ..] the psychoanalyst who believes in the irresponsible unconscious does not treat the symptom and does not cure it. It is urgent to consider the responsibility for what is unconscious" (2012, p.21). This way of thinking guides us when treating patients in the most different situations, taking into account the complaints: loss of joy in life, guilt, hopelessness, social inhibition, anxiety, among others.

With such demands met, we have the importance of the relationship that is established, in which the psychoanalyst holds the subject in question, questioning him and bringing him into the picture as a subject of potential and authentic before this other who is an observer and castrator, very often, the analyst. "In other words, it is a question of transforming the symptom-answer into the symptom-question" (Quinet, 2003, p. 19). This way, during the period in which the shift took place, we had the privilege of listening and intervening on a wide range of topics.

Lacan's first proposal is, Antonio Quinet tells us in his book 4+1: condition of analysis: "...punctuating. It is through the punctuation of the analysand's text that the analyst will make the unconscious exist" (2005, p.52). In this first moment, with listening and scoring, in addition to filling out the anamnesis form for the duty, we also transform the common speech into a manifestation of the unconscious. The above-mentioned author tells us: "if we consider the sentence as the signifying chain, it is when it ends that we will find the meaning of the beginning of the sentence, in a retroaction" (Quinet, 2005, p. 52).

Freud's learning and words remain: "I don't force patients to continue the treatment for a certain period of time; I allow everyone to interrupt it whenever they want" (1913, p. 145). The interruption is part of the patient's resistance, as Freud assures us in the previous text cited and entitled: About the beginning of the treatment (recommendations on the technique of psychoanalysis I).

THE DUTY: SUPERVISION

By exposing what the patient had reported to the psychology doctor on duty – and now for the professor – possible readings emerged, there was never any lack of guiding literature, different authors were read and even cited here. As it is a shift, we do not have the guarantee that the patient will return in the next session - as mentioned earlier in the short excerpt of the clinical case - thus, it is necessary in this case to intervene at the right time: "So, say everything that it passes through the mind" (Freud, 1913, p.150). At that moment, the supervisor professor of the shift helped us with possible interventions that could be made; highlighting, mainly, the patient's speech; the analyst with his floating attention must take the subject out of the jouissance position in which he finds himself; for this, the 'game' of signifiers will be used in clinical language: "... to hook the subject ridden by the signifiers of his alienation to the Other" (Quinet, 2003, p. 20). With that, then, we ask: "The I think through which the subject will reveal itself" (Lacan, 1979, p. 39).

Furthermore, it was possible to work during the supervisions, some points about the Freudian text, Grief and Melancholia. In particular, we highlight the issue of melancholy, configured by supervision as an identification of the self with the lost object, thus 'the subject gets lost', he loses the self. In this work - Mourning and Melancholia (from 1915) - Freud makes a distinction between

the two concepts. The first, grief, would be a reaction to the loss of someone, a loved one and/or an object; to know:

"The distinctive mental traits of melancholia are a deeply painful discouragement, the cessation of interest in the outside world, the loss of the capacity to love, the inhibition of any and all activities, and a decrease in feelings of self-esteem to the point of finding expression in self recrimination and self-debasement culminating in a delusional expectation of punishment" (Freud, 1915, p. 142).

In melancholy, in turn, what was lost is obscure to us, the subject knows he has lost something, but he does not know what he lost. Unlike mourning, in melancholia, the object was removed from consciousness, which no longer registers anything in the unconscious about its loss.

Finally, the supervisory function of a young psychology student, especially a future psychoanalyst, is: "...except for catastrophic situations, it must be to authorize the therapist, to inspire him/her confidence in their own actions, without which none healing will be possible" (2004, p.124) – I use the beautiful words of Contardo Galligaris in his book Letters to a young therapist to end the supervision.

DISCUSSION

As an academic modality with a clinical bias, the shift is not limited to the clinical school and can be applied in other institutions such as: schools, hospitals and judicial institutions. Furthermore, the psychological duty also provides the psychologist in training with real contact with everyday situations in an office, helping to overcome difficulties and uncertainties to some extent, promoting a better relationship between theory and practice. After all, it is not Freud who explains, as common sense says; and yes, it is the subject/patient who explains. Psychoanalysis arises from practice for the construction of theory and not its opposite. Despite being based on the Rogerian theory, in its emergence, the shift can happen with other lines of psychology; as a basis for promoting listening and psychological counseling. Here, then, let us take psychoanalysis as a possibility. As a result of this process, the transmission of psychoanalysis. And, given the different possibilities of occurrences, whether with returns or not from patients treated, listening and experience in our little history as analysts remained.

Therefore, in this psychological dimension discussed, this work must be concluded until the present moment, that the modality of psychological duty in the face of current demands has its due place and importance, as well as in the academic life of the on-call intern who was given the opportunity in his training psychological as well as for the individual who was looking for or referred to the service provided, this is the way in which the collective force is constituted, whose life is built in a constant movement of learning; building and deconstructing, never finished or finished, just begun; like here, in the short journey on the journey of listening, studying and writing. A path that I don't even know the length of the route and the size of the step. So, finally, walk! After all, it is up to the students themselves (we look for) to look for the answers to their own questions.

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