

SYMPTOMS AND SIGNS VERSUS TRANSFERENCE AND SPEECH

Psychoanalysis and Clinical Diagnostics¹

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The Muse of History

“In the medical tradition of the eighteenth century, the disease was observed in terms of *symptoms* and *signs*. These were distinguished from one another as much by their semantic value as by their morphology. The symptom - hence its uniquely privileged position - is the form in which the disease is presented: of all that is visible, it is closest to the essential; it is the first transcription of the inaccessible nature of the disease. [...] The symptoms allow the invariable form of the disease - set back somewhat, visible and invisible - to *show through*. The sign announces: the prognostic sign, what will happen; the anamnestic sign, what has happened; the diagnostic sign, what is now taking place. Between it and the disease is a distance that it cannot cross without accentuating it, for it often appears obliquely and unexpectedly.”² In this passage from The Birth of the Clinic, Michel Foucault describes one of the medical ‘codes of knowledge’ at the end of the 18th century, showing that one and the same phenomenon, namely illness, underwent an epistemological transformation and was regarded as a different object of study, following a reorganisation within the prevalent bodies of knowledge and the power they confer upon specialised observers. Foucault points out that medical science at the end of the 18th century did not distinguish itself by its primary focus on what is visible, nor by a particular conception of illness itself, but rather by a modified relationship between the patient, his or her illness and the specialist confronted with it. According to Foucault, the position of the medical doctor at the end of the 18th century differed from the one he had occupied in ancient times and during the Middle Ages, because he was now able to rely on the environment of the clinical institution, which gave him the power to make new decisions. Within this context, illness was conceived as a complex of symptoms and signs, which the specialist had to recognize if he wanted to make a firm decision about the nature and the seriousness of the disorder, and the appropriate level of treatment.³

However different the symptoms and signs under which 18th century illness presented itself may have been, in no time a process took place within clinical practice through which the former were transformed into the latter. In this way, a symptom - an attack of fever, a cough, vomiting, etc - not only gave the specialist an indication of an underlying pathological condition, but also provided him with information about the history, the present situation and the future of the patient: “At last, there emerges on the horizon of clinical experience the possibility of an exhaustive, clear, and complete reading: for a doctor whose skills would be carried ‘to the highest degree of perfection, all symptoms would become signs’, all pathological manifestations would speak a clear, ordered language.”⁴ Such a prophetic statement tallied with the sensualist ideas of Etienne de Condillac, for whom a perfect science equaled the development of a language that completely corresponds with empirical reality.⁵ Yet it also supported the philosophical projects of Descartes and Hegel, for whom a concept (thought, essence or universality) could eventually coincide with a concrete reality (thing, existence or particularity).⁶ Most

important, however, is that according to Foucault a medical act in which an illness is diagnosed in terms of symptoms functioning as signs, not only accommodated a certain form of pathology, but also the patient suffering from it. For the medical doctor, it was quite easy to identify the patient with her or his illness and to transform the person affected by sickness into a sick person. In this way, patients who could previously claim that they were *having* an attack of fever, now had to say that they *were* fever-patients. This process is usually called reification, that is to say the creation of an existence through the mere application of a name.

Foucault's ideas in The Birth of the Clinic concerning the relationship between the establishment of knowledge and the power structures in somatic medicine testify to a generalization of an opinion he had already formulated in Madness and Civilisation, considering the origin of madness as a specific nosological category.⁷ One of the pivotal theses of Foucault's *magnum opus* is indeed that the construction of specialized asylums at the end of the 18th century, in keeping with the humanitarian beliefs of William Tuke and Philippe Pinel, coincided with the scientific discovery of madness, which spread during the entire 19th century, following the development of psychiatry as an acknowledged subdiscipline of the medical sciences.⁸ The way in which the 18th century alienists concluded on the existence of madness in a patient was quite similar to the prevailing diagnostic principles in somatic medicine. Observed symptoms on the level of reason were considered an indication of psychopathology and subsequently transformed into signs expressing the nature, the course and the outcome of the illness, and covering the patient's existence in an objective and unambiguous manner. In Madness and Civilization, Foucault wrote: "Every madness and the entire madness must now have an external equivalent; or, to be more precise, the essence of madness will be to objectify the human being, to dislodge him from himself and eventually to exhibit him on the level of a pure and simple nature, on the level of things."⁹ Foucault further emphasised that the external equivalents were not necessarily located within the realm of delusion, but could also adopt the form of an assault, a state of elation, disinhibition, irresponsible behaviour, etc. In the latter case, J.E.D. Esquirol used the term 'partial madness' (*folie partielle*), whereas others preferred 'moral madness' (*folie morale*) and still others advocated the categories of 'lucid madness' (*folie lucide*) and 'reasoning madness' (*folie raisonnante*).¹⁰ Nevertheless, delusion as such remained the most important, external and objective sign of madness.

Throughout the 19th century, the scientific ideal of objectivity became ever more influential, the medical doctor progressively consolidated his position as a highly respected citizen within society, and the asylum, originally conceived as a place of seclusion, was gradually transformed into an institution of care. The medical code of knowledge expanded and was used within a larger variety of disciplines. In this way, medical doctors did not only recognize syphilis by genital exanthems, alienists did not only diagnose madness by delusions, but neurologists also determined hysteria by a specific, objective-visual picture. Following Foucault, it could be argued that this neurological development did not derive its singularity from a new orientation towards the visible, but rather from the approach of known entities, for example hysteria, via a new conceptual apparatus, more in particular via the definition of symptoms and signs pointing to a specific state of being. As far as hysteria is concerned, such an approach was already embraced by Pierre Briquet in his Traité clinique et thérapeutique de l'hystérie, dating from the middle of the 19th century.¹¹ Briquet freed hysteria from the womb in which it had been locked up since ancient times and designated it as a disease of the brain, in which paralysis, contractions and insensibility were regarded as the most typical manifestations. During the

1870's, this clinical picture of hysteria, which primarily consisted of sensory and motor disorders, became the pathognostic image of the hysterical illness and the hysterical patient, and it reached its climax in the multipartite iconographies of the Salpêtrière, in which hysterics performed as genuine clinical acrobats.¹²

Of course, the influence of Jean-Martin Charcot in these matters must not be underestimated. In this respect, Katrien Libbrecht asserts: "The master is seeking to define a clinical type, a ground form to which every individual case can be traced back and upon which a diagnosis can be based - a nosography of hysteria. This means that Charcot attempts to introduce a scientific approach to hysteria. His method is that of observation, description and systematization of what presents itself to the eye: Charcot spoke of himself in terms of a *visuel* [...] In subjecting hysteria to his anatomico-clinical method it becomes an illness just like any other and it enters into the scientific realm of neurological knowledge."¹³ Mark Micale confirms this point, arguing that, between 1870 and 1880, Charcot succeeded in imposing a significant degree of semantic and nosographic stability on the concept of hysteria. Yet he adds that the 1870's were probably the only period in the history of medicine in which medical doctors actually agreed about the symptomatological composition of the hysterical entity.¹⁴ After Charcot, discussions concerning the typical manifestations, the nature and even the existence of hysteria again dominated the medical scene.¹⁵ Foucault formulates a similar idea with regard to the scientific status of madness at the end of the 19th century: "Madness was not what people thought it to be, nor what it pretended to be; it was indefinitely smaller than itself: a whole of persuasion and mystification. [...] And through a peculiar reversal, scientific reason goes back nearly two centuries, to a period in which the boundaries between madness, false madness and simulated madness were poorly established. [...] So, beyond the empty forms of positivistic reasoning only one concrete reality remains: the couple medical doctor-patient, in which all alienations are summarized, entangled and disentangled."¹⁶

Fin de siècle Diagnosis

It is interesting to compare this historical development with the present situation in the field of clinical diagnostics, whereby a number of broad questions arise. What is the current position of power occupied by the medical doctor and the psychiatrist in particular? Which decisions can he or she take and to what effect? How is (psychic) illness determined? What is the relationship between patient and practitioner? To what kind of influences is this relationship liable?

These days, the practitioner's position of power is presumably more ambiguous than in the 19th century. On the one hand, the patient basically has the liberty to choose a medical doctor, to verify his or her decisions by consulting other medical doctors and even to help design a treatment plan. Save rather exceptional situations of forced treatment or forced non-treatment - in which people are for example referred to a treatment unit on the basis of a juridical measure, or removed from a treatment unit as a result of a crisis - the patient can in principle also autonomously decide how, where and when treatment will take place. Yet, on the other hand, this basic liberty of the patient is strongly reduced under the influence of two main developments. Firstly, the health care system itself restrains the liberty of the patient, to the extent that for example a completely liberal organisation causes those in dire straits to be put at the bottom of the waiting list for admission, or implicitly directs them to public institutions, where the quality standards are considerably lower. Secondly, medical assistance has acquired such a degree of complexity that

patients rarely have an overview of, let alone an insight into the kind of facilities that are generally available. The result is that they usually have recourse to what presents itself most directly and conveniently, relying on the idea that the other will have the best of intentions and will refer him or her to a specialist if necessary.

Roughly the same process takes place on the level of the available technologies, and of the strategies and products for diagnosing and treatment. Their impenetrability obliges the patient to put his or her trust in the specialist, in his or her body of knowledge and even more so, in his or her desire to use this knowledge as well as possible in view of other or his own well-being. However, precisely upon this last point a serious doubt can be thrown, for economic developments have influenced the medical profession to such an extent that it has been transformed into a good business and a fine trade. High-technology machines certainly allow for better diagnosis and more adequate treatment, but the tremendous cost of the purchase and the usage of these devices is responsible for the fact that they first have to pay and are only in the second place considered to do what they are really designed for. The situation in which a medical doctor tries to sell the patient his product as quickly as possible instead of providing him or her with physical or psychic well-being is definitely not a hypothetical one. In this case, the medical doctor becomes someone who trades rather than treats. Overall, the present relationship between patient and practitioner seems to be such that the patient can basically participate in the processes to which she or he is subjected, whereas the social organisation, the technological complexity and the economic context of these processes generally reduce the patient's involvement, giving the practitioner new power.

By contrast, current nosological systems and clinical diagnostics hardly differ from what was common during the 19th century. Somatic illness and psychopathology are still determined on the basis of symptoms functioning as signs. Disorders are recognized through prototypical, pathognostic phenomena, which after being classified and quantified represent the pathological status of the patient. Furthermore, the clinical field is still dominated by the specialist's observation of an object and his or her careful distinction of relevant and irrelevant phenomena, i.e., of manifestations that are meaningful and others that are not. Both on the basis of what the patient relates about her or his state of health and on the basis of signs collected in the medical examination, the practitioner constructs a pattern that refers to a certain type of pathology. Thanks to technological progress though, the contemporary medical doctor must not restrict himself to the external equivalents of the illness, since his or her equipment allows him or her to look for internal equivalents too. Yet the process of the detection of internal signs usually does not come into operation until the external ones are lacking, or until they are not decisive in gravity and number.

On the whole, the same method is used within psychiatry. The categories of mental disorders included in the diagnostic manuals function as prototypical examples of states of psychic illness that can be determined through observation and deduction. Nevertheless, the univocal empirical recognition and delineation of mental disorders remains a psychiatric sign, since a perfect objectivity and a fully adequate categorical system are impossible to realize. Current diagnostic systems for mental disorders have many epistemological shortcomings, which are often acknowledged by psychiatrists themselves, but they continue to be used, in many cases because professionals are convinced that there is nothing better available. Of course, the question is what this better thing would be: a more guaranteed objectivity through a

system with more or less differentiations, or a radically different approach? In any case, for the contemporary psychiatrist symptoms and signs still play a major part in the process of diagnosis, in which the external equivalents of a disorder are often reduced to one or more prototypical phenomena. Psychosis is commonly diagnosed on the basis of delusions and hallucinations, the actual contents and/or absence of which may help the professional to distinguish between paranoia and schizophrenia.¹⁷ Where it is not replaced by the so-called 'Briquet's syndrome' or the alleged 'histrionic personality', hysteria is commonly diagnosed when sexual intrigues and narcissistic theatricality are important aspects of the patient's behaviour. For the diagnosis of psychopathy (anti-social personality disorder), a repetitive criminal conduct is crucial, whereas perversion (paraphilia) is inferred from unusual, bizarre or socially unacceptable sexual interests. If the external equivalents are missing, neurobiological equivalents frequently bring relief and sometimes the diagnosis of a 'masked manic-depressive disorder' (or 'bipolar affective disorder') is merely based on the patient's positive reaction to lithium.¹⁸

Despite the present complexity of the relationship between patient and practitioner, and despite the confusion surrounding the scientific ideal of objectivity at the end of the 19th century, it can be observed that current clinical practice is largely based on the same code of knowledge as, for example, the medical-scientific enterprises of Briquet and Charcot. It is moreover to be expected that the failure of this model will not reveal itself within the next couple of decades, because it is strongly sustained by the economic dynamics of costs and expenditures. From an economic point of view, it is worthwhile investing time and money in the development of high-quality systems based on observation and registration, because these devices pave the way for an efficient diagnosis and a rapid initiation of specially designed treatment programmes, which makes treatment itself more cost-effective and less financially aggravating for the state and the citizen. And although the object of study is continuously withdrawing itself, the process of objectivation is not questioned. On the contrary, it is further stimulated, resulting in the fact that symptoms which seem to escape the acknowledged clinical pictures are newly classified, equipped with new meaning and eventually labelled as new objective disorders: post-traumatic stress disorder, narcissistic personality disorder, multiple personality disorder, chronic fatigue syndrome, etc. In support of the idea that the ideal of objectivity has a very promising future, it can still be pointed out that, in recent years, known entities such as schizophrenia, Alzheimer's disease and Gilles de la Tourette syndrome have again presented themselves to observers in the guise of a new object of study, namely the gene. Again, the scientific goal is to develop a language and a machinery that enable specialists to detect, diagnose and treat various disorders on the basis of univocal equivalents of pathology.

Contrary to what Foucault suggests concerning the global tendency within psychiatry at the end of the 19th century, the current fin de siècle does not really show a clear convergence in the direction of Freud, neither within psychiatry, nor within the sciences in general.¹⁹ On the contrary, it looks as if psychoanalysts are currently more than ever obliged to endorse, control and guarantee the validity of their theory and the effectiveness of their practice, in order to retain their professional role in society. Surely, this does not imply that psychoanalysis is faced with the choice of either adopting the prevailing norms of science, or abolishing itself, but rather that it is obliged to clarify and to underpin its own methodology and epistemology.

Psychoanalysis and Diagnostics

In his assessment of the contribution of psychoanalysis to clinical diagnostics and treatment, Foucault emphasizes that Freud launched a fundamental critique of the medical code of knowledge, whilst giving the impetus to the development of a radically different approach. Freud “has abolished silence and vision, he has eliminated the acknowledgement of madness by itself in the mirror of its own spectacle, he puts the agencies of condemnation to silence.”²⁰ In another context, Foucault even more radically contends “that the critique of psychiatry, as it was formulated, would have been impossible, even from a historical point of view, without psychoanalysis.”²¹ These bold assertions might give the impression that Foucault is very keen to eulogize the entire Freudian enterprise as another revolutionary rupture, but this is only partially the case. Indeed, Foucault also argues that the introduction of psychoanalysis resituated the locus of clinical power, which was previously divided between the medical doctor and the asylum, by centralizing it in the figure of the analyst, who was even more than the former alienist in the position to become a thaumaturge. Whereas the 19th century alienist was a medical doctor on the side of, or sometimes even within the service of an asylum, the analyst became a healer without any other frame of reference than himself or herself and the disposition Freud had created.

To say that Freud introduced speech where there was previously only silence and that he replaced the scrutinizing eye of the medical doctor by the attentive ear of the analyst has become proverbial, if not to say a cliché. That the transference relationship between patient and analyst places the latter in a powerful position, is not to be denied. Neither is it to be disputed that some analysts insidiously take advantage of their position of power within the treatment: i) to keep patients in analysis in order to secure their own income; ii) to advise patients to take decisions they themselves would have liked to take but never dared to; iii) to mould patients according to their own model; iv) to monitor the information circulating within a psychoanalytic society and v) to maintain their own position by anticipating the moves of rivals. However, it certainly does Freud credit - and Foucault seems to forget this - that he has relentlessly questioned, reformulated and specified his own position, both in public and in his writings. It also does Freud credit - and Foucault also seems to forget this - that he has at least developed some measures to prevent the analyst from misusing, that is to say from enjoying the power connected with his position. They include the training analysis of the future analyst, the psychoanalytical association, the analytical training programme, the re-entering of the training analysis, supervision etc.²²

Foucault divulges that the psychoanalytic project comprised a fundamental critique of the classical medical model, inasmuch as it generated radically different principles for diagnosis and a completely different organisation of the treatment. At this point, however, he does not specify the nature and the extent of the psychoanalytic innovations, for which there is of course the excuse that he has no intention of writing a history of psychoanalysis. Upon scrutiny, there are relatively few passages in Freud's works in which he addresses the issue of diagnostics. Yet, when Freud did air his concern, he time and again relativised the importance of the observed clinical picture. Freud's preoccupation with diagnostics is primarily situated between 1890 and 1895, a period in which he initially looked for sound criteria to differentiate phobia, obsessional neurosis and hysteria, eventually concluding, in the final chapter of the Studies on Hysteria, that the most common neuroses are “to be described as *mixed*”. At the same time, Freud expressed his dissatisfaction with the fact that the

diagnosis of hysteria is all too often made on the basis of supposed characteristic signs such as anaesthesia and convulsive attacks, or on the basis of the most salient traits of the picture.²³

Some eighteen years later, in 1913, Freud emphasized the importance of the diagnosis before the start of the treatment, using this as one of the motives for the preliminary conversations, or what he called the 'trial period' (*Probezeit, Erprobung, Sondierung*) before the actual commencement of analysis.²⁴ Formulating a correct diagnosis was crucial to Freud, owing to the presupposed indications and contra-indications for psychoanalytic treatment. In this respect, he referred to what he had stated some ten years before, in 1905, in a lecture entitled *On Psychotherapy*, held before the cénacle of the *Wiener medizinisches Doktorenkollegium*. In this lecture, Freud had proffered some four (contra)indications for psychoanalysis, which must now appear as highly droll and completely obsolete, not only due to the terms in which they were formulated, but also because of the unlikely demands they put on the patients. Freud stated that patients must "possess a normal mental condition", that they must not be affected by "neuropathic degeneracy", ought to be younger than fifty - which was precisely Freud's own age at the time - not requiring any urgent intervention, be "educable" and "driven to seek treatment by their own sufferings."²⁵ The only two disease types Freud considered very suitable for psychoanalytic treatment were hysteria and obsessional neurosis, with which he proudly notified the audience that in this way "precisely the most valuable and most highly developed persons" could be treated.²⁶ At once it becomes clear why someone had the idea to say that psychoanalysis is only applicable to 'YARVIS' - patients - those who are Young, Attractive, Rich, Verbal, Intelligent and Sophisticated. However, we must not forget that Freud's principal intention was to convince the medical establishment that his discovery was altogether valuable. From this point of view, it is obvious that he restricted the relevance of psychoanalysis to a small and reasonably well-delineated part of the clinical field, for which the medical world was still looking for an appropriate remedy. If Freud wanted to count on the sympathy and the approval of the *éminences grises*, it must have been evident to him that he could not present a method that was purportedly adequate under all circumstances and for everybody. That the list of (contra)indications was rather an *ad hoc* construction also appears from the fact that Freud later restricted the contra-indications for psychoanalysis to the so-called 'narcissistic neuroses', comprising dementia praecox, paranoia and melancholia, for which he considered psychoanalytic treatment only possible after fundamental methodological adjustments.²⁷

According to Freud, the differential diagnosis between neurosis and psychosis was of cardinal importance to the overall possibility and the general success of psychoanalytic treatment. A neurosis wrongly diagnosed as psychosis causes the patient to be unjustly *excluded from* treatment, whereas the reverse leads to the patient being unjustly taken into treatment. Such mistakes would be quite rare if the process of differential diagnostics was altogether easy. But in Freud's opinion, this was not the case: "Often enough, when one sees a neurosis with hysterical or obsessional symptoms, which is not excessively marked and has not been in existence for long - just the type of case, that is, that one would regard as suitable for treatment - one has to reckon with the possibility that it may be a preliminary stage of what is known as dementia praecox ('schizophrenia', in Bleuler's terminology; 'paraphrenia', as I have proposed to call it), and that sooner or later it will show a well-marked picture of that affection. I do not agree that it is always possible to make the distinction so easily."²⁸ Freud's suspicion concerned psychosis

hiding under the mask of neurosis, but there is no reason to believe that the reverse could not happen and that it was impossible for a neurosis to present itself under the form of a psychosis.²⁹

Freud did not give any concrete recommendations about how to proceed in determining a neurosis or a psychosis. He merely underscored the difficulty of the diagnostic enterprise as a whole, pointing out the catastrophe of the diagnostic mistake and quipping at the representatives of clinical psychiatry: "I am aware that there are psychiatrists who hesitate less often in their differential diagnosis, but I have become convinced that just as often they make mistakes. To make a mistake, moreover, is of far greater moment for the psycho-analyst than it is for the clinical psychiatrist, as he is called. For the latter is not attempting to do anything that will be of use, whichever kind of case it may be. He merely runs the risk of making a theoretical mistake, and his diagnosis is of no more than academic interest."³⁰

In *The Question of Lay-Analysis*, written in 1926, Freud formulated similar ideas on diagnosis as in *On Beginning the Treatment*. A neurotic symptomatology does not necessarily imply neurosis; it can also be the manifestation of a different psychic or physical process. Again, Freud considered diagnosis of prime importance and moreover demanded that the analyst not only pay attention to the difference between neurosis and psychosis, but also to the distinction between psychic and organic disorders, although to Freud, doubts concerning the latter seemed easier to rule out than in the case where the analyst had to decide on the nature of the psychic organisation.³¹ The fundamental difficulty of diagnosis eventually inspired Freud to compare the diagnostic process with the ordeal by water, with the analyst (rather than the patient) in the position of the victim. Whatever symptoms a patient manifests, however recognizable the clinical picture may be, the analyst ought not to be jumping to conclusions and should only make a decision when the analytic work with the patient has made some progress. Hence, from a Freudian perspective, the diagnosis is not formulated before or at the onset, but rather during the analytic process and 'by deferred action' (*nachträglich*).³² And even then, it was according to Freud not appropriate to proclaim such a 'deferred diagnosis' as a conclusive proposition, since an analyst can never be sure that the indications provided by the analytic process are reliable and that the treatment will not take a completely different turn. Paradoxically, the most correct diagnosis is the one that is formulated *after* the treatment has finished, but as in the ordeal by water, this is of course a point of no return. In other words, Freud argued in favour of a 'dynamic diagnosis', which is continuously being developed, specified and possibly revised during the course of the treatment.

But what about the criteria on which a psychoanalytic diagnosis is based, if it does not proceed from internally and/or externally observable phenomena, and reported symptoms and signs? There are hardly any propositions concerning these criteria in Freud's works, but his general nosological categories of transference and narcissistic neurosis at least indicate that the relationship between the analyst and the patient functions as a guideline for the differential diagnosis between neurosis and psychosis. Freud filed anxiety hysteria (phobia), conversion hysteria and obsessional neurosis under transference neurosis, because in these cases the positive or negative emotional tie (*Gefühlsbindung*) connecting the patient to the analyst "possesses this extraordinary, and for the treatment, positively central, importance".³³ Conversely, Freud called dementia praecox, paranoia and melancholia narcissistic neuroses, because the patients "have no capacity for transference or only insufficient residues of it".³⁴ Hence, Foucault is right if he states

that Freud was “the first to accept the couple medical doctor-patient in all earnestness”, the first “to follow its consequences in all rigour”.³⁵ Indeed, Freud replaced the traditional and current ‘objective diagnosis’, made on the basis of the assessment of signs, by a radically different, ‘intersubjective diagnosis’, made on the basis of the assessment of a relationship.

However, this is not the only and perhaps not even the most important criterion Freud used, although it is probably the most discussed and the most elaborated one. In his 1915 metapsychological essay *The Unconscious*, Freud distinguished between schizophrenia on the one hand and hysteria and obsessional neurosis on the other hand, on the basis of an evaluation of the patient’s speech. In Freud’s view, a schizophrenic uses ‘organspeech’ (*Organsprache*), because words that are somehow connected to the body are taken literally and charged with a massive, unshakeable meaning.³⁶ Freud added that in cases of schizophrenia the relationship between the ‘presentation of the word’ (*Wortvorstellung*) and the ‘presentation of the thing’ (*Sachvorstellung*) is broken and that symptoms can be conceived as the result of word-associations that are not connected to things anymore.³⁷ From another context, it becomes apparent that Freud did not only apply this principle to what is at stake in schizophrenia, but also to the issue of dementia praecox.³⁸ These considerations on the features of speech in psychosis could lead to the designation of a second psychoanalytic criterion for the differential diagnosis of neurosis and psychosis. Whereas the first criterion could be defined as the patient’s relationship to the analyst, this criterion can be specified as the patient’s relationship to language.

This Freudian diagnostic innovation was further developed by Jacques Lacan. From the very beginning of his career, Lacan relativized the importance of the clinical picture for making a diagnosis, in favour of relational and language aspects. Already in his doctorate, from 1932, he formulated the following diagnostic criteria for self-punitive paranoia: “The diagnosis is made on the basis of the preceding structure of the personality of the subject and on the basis of certain etiological and symptomatic peculiarities of the psychosis, in relation to the common picture of paranoia.”³⁹ As far as the first criterion, “the preceding structure of the personality of the subject”, is concerned, Lacan advocated an evaluation of the patient’s functioning within professional and sexual relationships. He did not define the “structure of the personality of the subject” as a particular set of character and/or other traits, but rather as a specific way of dealing with others, within the socio-cultural environment at large. Similarly, Lacan did not conceive the second criterion, the “etiological and symptomatic peculiarities”, as the salient and/or singular individual characteristics, but rather as the patient’s attitude towards sexuality and family life. In this respect, Lacan for example indicated that in the aetiology of psychosis, a “trivial organic process” (*processus organique fruste*), for example a menopause problem, is frequently found, next to a “transformation of the life situation”, for example marriage or divorce, and an event that can be qualified as an “affective trauma”. He also pointed out that a “life conflict”, with a “strong ethical resonance” and which is “quite often connected with the patient’s relationships with parents and siblings” can persist for many years.⁴⁰

From this, it can be inferred that Lacan did not endorse the traditional diagnostic principles, but shifted the clinical point of application from the patient’s manifest symptoms and signs towards his or her professional, sexual and familial relationships. In doing so, he followed the Freudian diagnostic principles, although at the time of his doctoral dissertation he had not yet given himself a place within psychoanalysis. In the course of his psychoanalytic itinerary, Lacan refined and

specified this clinical diagnostic paradigm, according to the two fundamental lines of his theoretical elaboration, namely the signifier and the object. On the one hand, “the patient’s functioning within a socio-cultural context” was redefined as the relationship between the subject and the Other, that is to say between the subject and the structures of language and law. On the other hand, “the patient’s attitude towards sexuality” was reformulated as the relationship between the subject and the lack that is produced in and by the Other, or, in more technical terms, between the subject, the phallus and the object *a*. As such, a Lacanian psychoanalytic nosology concerns the relationships between the subject, the Other and the object, in which the importance of symptoms and signs as reliable indications of psychopathology is further reduced.

In Lacanian doctrine, clinical phenomena are not completely disconnected from psychic dynamics, or ‘psychic structure’, but the nature and the gravity of the phenomena do not allow the clinician to draw conclusions about psychopathology. There is no complete disconnection, because according to Lacan the structure manifests itself on all levels of psychic organisation, and thus also on the level of the clinical phenomena. In his third seminar, The Psychoses Lacan for example stated: “[A]nalogous structures can be found at the level of the composition, motivation, and thematization of a delusion and at the level of the elementary phenomenon. In other words, it’s always the same structuring force, as it were, at work in a delusion, whether it’s the whole or one of its parts that is under consideration.”⁴¹ For the clinician, it is a matter of investigating, beyond what is immediately visible, the way in which symptoms are organised and structured. This means that it is the clinician’s task to assess: i) which place the symptoms occupy within the patient’s life history; ii) how the patient deals with the symptoms, both in speech, in imagination and in practice; iii) which internal and external influences the symptoms are subject to; iv) whether or not the symptoms are addressed to somebody; and v) what is the Other’s contribution to the symptoms in general.

Of course, these guidelines are still inadequate for the concrete distinction of psychosis and neurosis on the basis of transference and speech. Some of Lacan’s followers have elaborated on these criteria, introducing rules of thumb, together with a new form of rigidity: “It suffices when a patient says “I am hallucinating”, or, “I have got hallucinations” to discard psychosis deliberately and with certitude, and to envisage a toxic or neurologic etiology. The necessary and sufficient formula of the psychotic expression of the phenomenon is the one that is stereotyped by misrecognition (*méconnaissance*): “They tell me that...”⁴² Such a statement makes clear that different criteria are in themselves not a guarantee for a certain flexibility on the part of the practitioner, and that an essential respect for the patient is not incorporated in any diagnostic system, whether psychiatric or psychoanalytic.

ENDNOTES:

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² M. Foucault, The Birth of the Clinic: An Archaeology of Medical Perception (1963) (trans. A.M. Sheridan Smith), London, Tavistock, 1973, p. 90.

³ Foucault’s vision of psychiatric history in The Birth of the Clinic was of course already adumbrated in Madness and Civilization and is governed by his emphasis on historical ‘epistemological ruptures’. In

recent years, this vision has prompted a number of criticisms among historians of psychiatry, the most influential and prominent figure amongst the critics being Roy Porter, who has argued against epistemological ruptures and in favour of historical continuity. Personally, I tend to agree with Andrew Scull, who acknowledges Foucault's unwarranted and unsubstantiated idea of 'rupture', without eliminating the possibility of radical historical changes. See, for example: R. Porter, Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency, London, Athlone, 1987; A. Scull, Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective, Berkeley/Los Angeles CA, University of California Press, 1989, pp. 13-19. Other critical analyses of Foucault will be found in the much acclaimed work by J. Goldstein, Console and Classify: The French Psychiatric Profession in the Nineteenth Century, Cambridge, Cambridge University Press, 1987, and in I.R. Dowbiggin, Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth-Century France, Berkeley/Los Angeles CA, University of California Press, 1991.

⁴ M. Foucault, The Birth of the Clinic: An Archaeology of Medical Perception, *op. cit.*, pp. 94-95. Foucault's own quotation is taken from J.B.E. Demorcy-Delettre, Essai sur l'analyse appliquée au perfectionnement de la médecine, Paris, 1818, p. 102.

⁵ See: E. de Condillac, Traité des Sensations (1754), Paris, Fayard, 1984.

⁶ This is indeed the implicit meaning of Descartes' 'cogito ergo sum' and Hegel's 'absolute knowledge'.

⁷ See: M. Foucault, Histoire de la folie à l'âge classique (1961), Paris, Gallimard, coll. Bibliothèque des histoires, Nouvelle édition, 1972. As is hopefully common knowledge by now, the 1965 English translation of this book is based on an abridged French edition that contains little more than half of the original work. A full English translation of the original is currently underway. Until this translation materializes, the non-francophones who would like to catch a glimpse of the ideas that are not included in the abridged English version can benefit from a 1990 article by Colin Gordon and the score of responses to it. See: M. Foucault, Madness and Civilization: A History of Insanity in the Age of Reason (1961) (trans. R. Howard), New York NY, Random House, 1965; C. Gordon, Histoire de la folie: An Unknown Book by Michel Foucault, History of the Human Sciences, 1990, III, pp. 3-26.

⁸ Eric Midelfort has criticized Foucault's ideas on the connection between the creation of the asylum and the introduction of the concept of madness, by pointing out that it is nonsense to assert that madness was not a medical problem before the advent of Pinel and that Pinel himself was tributary to some illustrious predecessors, among others Hippocrates and Galen. Recently, Gary Gutting has refuted Midelfort's first objection by drawing attention to the fact that Foucault never denied the medical treatment of lunatics during the Classical Period, but that he merely argued that these people were, despite their treatment, not regarded as 'sick'. Concerning the second objection, Gutting has shown that Pinel's borrowings from the Classical tradition do not undermine his conceptual and practical innovations. See: H.C.E. Midelfort, Madness and Civilization in Early Modern Europe: A Reappraisal of Michel Foucault, in B. Malament (Ed.), After the Reformation: Essays in Honor of J.H. Hexter, Philadelphia PA, University of Pennsylvania Press, 1989, pp. 258-260; G. Gutting, Michel Foucault's Phänomenologie des Krankengeistes, in M.S. Micale & R. Porter (Eds.), Discovering the History of Psychiatry, Oxford-New York NY, Oxford University Press, 1994, pp. 331-347.

⁹ M. Foucault, Histoire de la folie à l'âge classique, o.c., pp. 542-543. My translation.

¹⁰ See: J.E.D. Esquirol, Des maladies mentales considérées sous le rapport médical, hygiénique et médico-légal, Paris, Baillière, 1838. For 'folie morale', see: J. Falret, Études cliniques sur les maladies mentales et nerveuses, Paris, Baillière, 1889. For 'folie lucide', see: U. Trélat, La folie lucide étudiée et considérée au point de vue de la famille et de la société, Paris, Delahaye et Lecrosnier, 1861. For 'folie raisonnante', see: P. Sérieux & J. Capgras, Les folies raisonnantes. Le délire d'interprétation (1909), Marseille, Laffitte Reprints, 1982.

¹¹ P. Briquet, Traité clinique et thérapeutique de l'hystérie, Paris, Baillière, 1859. Mark S. Micale has indicated that Briquet's work experienced a certain revival during the 1980's, after Samuel B. Guze had redubbed hysteria as 'Briquet's syndrome' in a series of 1970's papers and after the American Psychiatric Association had included the term in the third edition (1980) of the Diagnostic and Statistical Manual of Mental Disorders (DSM). A complete English translation of Briquet's 1859 treatise is currently underway. See: M.S. Micale, Approaching Hysteria: Disease and its Interpretations, Princeton NJ, Princeton University Press, 1994, pp. 50-56. See also: M.N. Evans, Fits and Starts: A Genealogy of Hysteria in Modern France, Ithaca NY, Cornell University Press, 1991, p. 16 (note).

¹² See: D-M. Bourneville & P. Régnard, Iconographie photographique de la Salpêtrière (3 vols.). Paris, Delahaye et Lecrosnier, 1876-1880. See also: G. Didi-Huberman, Invention de l'hystérie: Charcot et l'iconographie photographique de la Salpêtrière, Paris, Macula, 1982; S. Gilman, Seeing the Insane. A Cultural History of Psychiatric Illustration, New York NY, Brunner-Mazel, 1982.

¹³ K. Libbrecht, Hysterical Psychosis: A Historical Survey, New Brunswick NJ, Transaction, 1995, p.41.

¹⁴ M.S. Micale, Approaching Hysteria: Disease and its Interpretations, *op.cit.*, p. 109.

¹⁵ Recent scholarly interest in Charcot has led to the publication of a number of new monographs, of which the study by Goetz, Bonduelle and Gelfand unquestionably deserves to be called definitive: W. Bannour, Jean-Martin Charcot et l'hystérie, Paris, Métailié, 1992; A. Lellouch, Jean-Martin Charcot et les origines de la gerontologie, Paris, Payot, 1992; J. Thuillier, Monsieur Charcot de la Salpêtrière, Paris, Robert Laffont, 1993; J. Gasser, Aux origines du cerveau moderne: localisations, langage et mémoire dans l'oeuvre de Charcot, Paris, Fayard, 1995; C.G. Goetz, M. Bonduelle & T. Gelfand, Charcot: Constructing Neurology, New York NY-Oxford, Oxford University Press, 1995.

¹⁶ M. Foucault, Histoire de la folie à l'âge classique, *op.cit.*, p. 529. My translation.

¹⁷ This does not mean that delusions and hallucinations are considered to be the hallmark of psychosis, nor that psychosis will never be diagnosed without these symptoms. It merely implies that there is a *privileged semiological relationship* between certain symptoms and certain mental disorders. For an excellent, up to date historical survey of the diagnostic value of hallucinations, see: G. Lantéri-Laura, Les hallucinations, Paris, Masson, coll. Médecine et psychothérapie, 1991.

¹⁸ See: E. Zarifian, Un diagnostic en psychiatrie: pour quoi faire?, in La querelle des diagnostics, Paris, Navarin, coll. «Cliniques», 1986, pp. 75-87; E. Zarifian, Les jardiniers de la folie, Paris, Odile Jacob, 1988, pp. 69-70.

¹⁹ For Foucault's claim, see: M. Foucault, Histoire de la folie à l'âge classique, *op.cit.*, p. 529.

²⁰ M. Foucault, Histoire de la folie à l'âge classique, *op.cit.*, p. 529. My translation.

²¹ M. Foucault, L'extension sociale de la norme (entretien avec P. Werner) (1976), in D. Defert & F. Ewald (Eds.), Michel Foucault. Dits et écrits, Vol. III (1976-1979), Paris, Gallimard, 1994, p. 77. My translation.

²² Freud introduced the principle of self-analysis (*Selbstanalyse*), as a condition for carrying out psychoanalysis, during the Second Psychoanalytic Congress at Nürnberg in 1910. Two years later, he reformulated this principle as the requirement to "undergo an analysis by someone with expert knowledge" (*selbst finer Analyse bel einem Sachkundigen unterziehen*) and he praised the Zurich school (Jung) for having formulated this demand. Eventually, in 1937, Freud wrote that every analyst should re-enter analysis every five years or so, a requirement no psychoanalytic association has ever taken seriously. See: S. Freud, The Future Prospects of Psycho-Analytic Therapy (1910d), Standard Edition, XI, p. 145; S. Freud, Recommendations for Physicians on the Psycho-Analytic Method of Treatment (1912e), Standard Edition, XII, p. 116; S. Freud, Analysis Terminable and Interminable (1937c), Standard Edition, XXIII, p. 249.

²³ J. Breuer & S. Freud, Studies on Hysteria (1895d), Standard Edition, II, p. 259.

²⁴ S. Freud, On Beginning the Treatment (1913c), Standard Edition, XII, p. 124.

²⁵ S. Freud, On Psychotherapy (1905a), Standard Edition, VII, pp. 263-264.

²⁶ *Ibid.*, p. 264.

²⁷ In On Psychotherapy, Freud claimed: "Psychoses, states of confusion and deeply-rooted (I might say toxic) depression are therefore *not* suitable for psycho-analysis; at least not for the method as it has been practised up to the present. I do not regard it as by any means impossible that by suitable changes in the method we may succeed in overcoming this contra-indication - and so be able to initiate a psychotherapy of the psychoses." A passage from An Outline of Psycho-Analysis, written in 1938, shows that Freud, despite his new conceptual framework of the second topography, defended this opinion until the very end: "If the patient's ego is to be a useful ally in our common work, it must, however hard it may be pressed by the hostile powers, have retained a certain amount of coherence and some fragment of understanding for the demands of reality. But this is not to be expected from the ego of a psychotic; it cannot observe a pact of this kind, indeed it can scarcely enter into one. It will very soon have tossed us away and the help we offer it and sent us to join the portions of the external world which no longer mean anything to it. Thus we discover that we must renounce the idea of trying our plan of cure upon psychotics — renounce it perhaps for ever or perhaps only for the time being, till we have found some other plan better adapted for them." See: S. Freud, On Psychotherapy, *op.cit.*, p. 264; S. Freud, An Outline of Psycho-Analysis (1940d [1938]), Standard Edition, XXIII p. 173.

²⁸ S. Freud, On Beginning the Treatment, *op.cit.*, p. 124.

²⁹ That delusions and hallucinations are not necessarily indications of psychosis and can also appear within a hysterical picture, had already been considered by psychiatrists at the end of the 19th century and contributed to the nosological confusion. For a detailed overview of opinions, see K. Libbrecht, Hysterical Psychosis. A Historical Survey, *op.cit.*, pp. 11-37. For relevant case-material, see: J.-C1. Maleval, Folies hystériques et psychoses dissociatives (1981), Paris, Payot, 1991. To a lesser extent, 19th century psychiatrists also considered the appearance of hallucinations in

obsessional neurosis. See, for example: J. Seglas, Leçons cliniques sur les maladies mentales et nerveuses, Paris, Asselin et Houzeau, 1895.

³⁰ S. Freud, *On Beginning the Treatment*, *op.cit.*, p. 124.

³¹ S. Freud. *The Question of Lay-Analysis* (1926e), Standard Edition, XX, pp. 240-243.

³² S. Freud, New Introductory Lectures on Psycho-Analysis (1933[1932]), *Lecture XXXIV: Explanations, Applications and Orientations*, Standard Edition, XXII, p. 155.

³³ S. Freud, Introductory Lectures on Psycho-Analysis (1916-1917[1915-1917]), *Lecture XXVII: Transference*, Standard Edition, XVI, pp. 443-445.

³⁴ *Ibid.*, p. 447.

³⁵ M. Foucault, Histoire de la folie à l'âge classique, *op.cit.*, p. 529. My translation.

³⁶ Freud wrote that "the process may go so far that a single word, if it is specially suitable on account of its numerous connections, takes over the representation of a whole train of thought." To illustrate this, he borrowed a fine example from a study by Viktor Tausk. It concerns a female patient who complains that her eyes are twisted, which she explains by referring to the hypocrisy of her lover, who was a real 'eye-twister' (*Augenverdreher*). See: S. Freud, *The Unconscious* (1915e), Standard Edition, XIV, p. 198-99; V. Tausk, *Über die Entstehung des 'Beeinflussungsapparates' in der Schizophrenie*, *Internationale Zeitschrift für ärztliche Psychoanalyse*, 1919, V, nr. 1, pp. 1-33. The idea of a single word being erected at the intersection of a large amount of thoughts was taken up by Lacan in his third seminar, The Psychoses, whereby he reformulated this process as the creation of a signifier whose meaning is unpronounceable because it is 'meaning as such'. See: J. Lacan, The Seminar. Book III: The Psychoses (1955-56) (trans. with notes R. Grigg), Edited by J.-A. Miller, New York NY-London, W.W. Norton & Company, 1993, p. 33.

³⁷ Indeed, Freud also believed that words can cover things. At one point, he even suggested that there is a certain 'natural' relationship between the order of things and the order of words. See: S. Freud, *Instincts and their Vicissitudes* (1915c), Standard Edition, XIV, p. 109-110.

³⁸ See: S. Freud, Introductory Lectures on Psycho-Analysis (1916-1917 [1915-1917]), *Lecture XXVI: Libido theory and Narcissism*, Standard Edition, XVI, p. 422.

³⁹ J. Lacan, De la psychose paranoïaque dans ses rapports avec la personnalité (1932), Paris, du Seuil, 1980, coll. «Points», p 268. My translation.

⁴⁰ *Ibid.*, 270-271. My translation.

⁴¹ J. Lacan, The Seminar. Book III: The Psychoses, *op.cit.*, p. 19.

⁴² Introduction critique à l'étude de l'hallucination, Scilicet, 1968, no. 1, p. 124. My translation.