Diagnosis in psychoanalysis[*]

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1 The question of nosological classifications

The question of diagnosis is not for the practising psychoanalyst a purely theoretical or academic one. It is of clinical and ethical importance, and it has more to do with decisions, that is, acts that we produce and which affect our patients directly, than with conceptual debates as to whether a certain patient fits in a certain category or whether a particular phenomenon should be regarded as a true symptom.

The expression 'differential diagnosis' is somehow redundant, as all diagnosis is differential, in the sense of involving the discrimination, on the basis of established knowledge, between mutually exclusive categories. To diagnose means to identify positively on the basis of typical or 'pathognomonic' (to use the medical term) traits, signs and symptoms, and it has never been good practice to diagnose only by exclusion ('It must be a psychosis because we have not found any traces of neurosis or perversion'). It has always been an essential epistemological and practical moment in medical practice. If, on the one hand, the need to respect the singularity of the patient has always been acknowledged in medicine (the doctor treats a singular patient, not an illness detached from the body which it affects), on the other hand the very idea of diagnosis, and of illness for that matter, imply the recognition that somatic responses are limited in scope and tend to adopt typical forms: a human body simply does not survive a temperature of, say 100 degrees Celsius, or a blood pressure of 450 over 220. Psychoanalysis, which is according to Lacan the 'last flower of medicine', inherited views on diagnosis well established in medicine over the centuries, although in some respects, as we shall see, has needed to go beyond them. In other words: if one is to go mad (and as psychoanalysts we deal with madness in its different forms), one is not at liberty to go mad in just any way. There is method in madness, that is, limits imposed by the way we are made as humans, or, as we prefer to say, by the structure—meaning: the structure of our body, the structure of our thinking and the structure of our relations with others, all of which are interdependent.

Psychoanalysis inherited the diagnostic categories prevalent in psychiatry at the end of the XIXth century. We must take into account that, although some nosological categories (melancholia, hypochondria, hysteria, paranoia) were by then centuries old, psychiatry itself as a discipline and psychiatric classifications were in their beginnings: the term 'neurosis' was introduced in the XVIII century; 'psychosis', only in the middle of the XIX century; 'dementia praecox' (precursor of 'schizophrenia') was coined by Kraepelin towards the end of the XIX century (Kraepelin 1919); the term 'schizophrenia' itself was only introduced by Bleuler in 1911 (Bleuler 1950). Freud, and then other psychoanalysts, introduced new diagnostic categories, but on the whole the psychoanalytic psychopathological classification has remained under the influence of the psychiatric classifications, even if the latter incorporated some of the categories proposed by psychoanalysts and if, at least within the Lacanian movement, psychoanalysis has followed a rationale for the classification of the different nosological entities which is not based on psychiatric practice exclusively, and which differs from it at some essential points.

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To put it briefly, and simply: in Freudian and Lacanian psychoanalysis the different psychopathological manifestations and the structures that underlie them are considered to be *productions* rather than *deficits* of the subject; they represent an *order* rather than a *dis*order, as contemporary psychiatry tends to view them. (American Psychiatric Association 1994) In his initial comments on the case of President Schreber, Freud says that, in the case of the psychoses (and the same could be said of any other 'mental disorder') the work of the psychoanalyst commences at the point where the work of the psychiatrist finishes; that is to say, the psychoanalyst is not contented, as the psychiatrist would be, in ascertaining that the patient's ideation (as expressed in his discourse) is delusional, that is, abnormal in relation to ordinary speech. (Freud 1911c, 17-18) The psychoanalyst is also interested in the content and style of the patient's speech, and then in its historical sources and its relations with the patient's life and circumstances. This interest, we must acknowledge, is not exclusively psychoanalytic: the phenomenological school in psychiatry, whose founder was Karl Jaspers (Jaspers 1968; 1997), and other schools in psychiatry have also been interested in the content of patients' delusions and other productions, in listening and understanding the patient's discourse, the differences with psychoanalysis lying in the interpretation of those productions and the interventions of the clinician based on those interpretations.

In psychiatric practice, a diagnosis is frequently not just a conceptual exercise, but has the most serious practical consequences for the patient. The diagnosis of psychosis may well have the effect for the patient of the end of his career, in a particular profession or as a citizen as a whole. In Australia (perhaps also in other countries) a diagnosis of 'personality disorder' or 'borderline personality disorder' may have disastrous consequences for the patient, as in contemporary psychiatric practice those categories are presumed to involve self-destructive, antisocial and attention-seeking behaviour which are not effectively treatable with the available instruments applied to the psychoses or the neuroses and therefore left in a therapeutic limbo.

Only a few days ago, at the trial of the murderer of Sweden's Foreign Minister, Anna Lindh, it was revealed that the man was refused admission at a psychiatric hospital the day before the murder. Presumably, somebody adopted a decision at the time on the basis of a diagnostic formulation. Now the court is waiting for another diagnostic formulation, to decide whether the accused goes to prison (if he is declared sane) or to a psychiatric hospital (if he is declared insane).

In psychoanalytic practice, it is not frequent, at least in private consulting rooms, that the analyst is required to produce a diagnosis of the patient for a third party, the diagnosis thus becoming something else than a clinical act. Psychoanalysts working in institutions may also be required to state a diagnostic opinion concerning the patient, and this may have consequences for the social and personal status of the patient, including the eligibility for psychoanalytic treatment. In these cases the analyst's diagnostic task has the most important effects on the patient's life.

But even outside these situations, diagnosis in psychoanalysis always has consequences for the patient, in that diagnosis is an integral part of the direction of the treatment, that is, the treatment's rationale and practical orientation, with its political (in the sense of its following a policy), strategic and tactical dimensions (Cf. Lacan's 'The direction of the treatment and the principles of its power'; Lacan 2002).

2 The direction of the treatment

For some psychoanalysts, diagnostic precision is apparently not as important in psychoanalysis as it is in medicine, where a clear diagnosis is the necessary condition for effective treatment. This notion is misleading: correct diagnosis is, and should be, as important in psychoanalysis.

The relatively diminished significance of a precise diagnosis is in part due, in the first place, to the fact that ostensibly in psychoanalytic practice urgencies are rather rare, and the psychoanalyst has, generally speaking, plenty of time to formulate a diagnosis. This, again, is a misleading notion: as in any other human endeavour, in psychoanalysis we are running out of time all the time, and it is not a very good idea to think that one has all the time in the world to produce a diagnostic mapping of the patient, since apparently this is not so essential in order to produce an effective intervention—an interpretation, or a psychoanalytic act.

In the second place, there is no consensus among ourselves as to the diagnostic categories that we use. Even within the Lacanian movement, where following Lacan's views an effort has been made to establish and employ logically and clinically consistent categories, there is no unanimity concerning diagnosis. This is in part a positive function of the evolution of psychoanalytic research and the necessary questioning of established notions, but also a function of the lack of clear understanding of a number of clinical phenomena which to this day remain obscure, or only very incompletely understood.

There is another, and perhaps more important reason, for what may appear to be a relatively diminished relevance of correct diagnosis in psychoanalytic treatment.

What has allowed psychoanalysis to maintain an identity in its nearly 110 years of existence is the method that Freud created. This method is a new form of discourse, which has introduced into the world a new type of social link and of treating and orienting jouissance. Freud defined psychoanalysis as involving three things: 1) a method of investigation of psychical phenomena; 2) a corpus of knowledge obtained through the application on this method; and 3) a therapeutic method based on the method of investigation. While acknowledging the affinity between psychoanalysis as a method of research and as a clinical method, Freud did separate them, as the clinical method involves experiences which are not academic, speculative or experimental.

The method that Freud created has virtually remained intact throughout the history of psychoanalysis, even if there has been considerable debate within psychoanalysis as to how to define and use it. Whereas psychoanalytic theory has evolved into a plurality of schools of thought, most psychoanalysts subscribe to the terms in which Freud established the method, as exposed in his so called 'technical' and other papers. It cannot be denied that different interpretations of the method effectively mean different practices of psychoanalysis; but if there is any sense in calling a variety of practices psychoanalysis, it is because despite the variations there is a common reference to the experience that Freud invented, represented by the fundamental rule of analysis (the rule of free association) and the position of evenly-suspended attention that Freud required for the analyst.

Freud applied the same method to the different types of neurotics and to some psychotics, and so did the analysts of the first generation. Freud noticed immediately that in the case of the psychotics the method did not work, or did not work as well as with neurotics. This led to his rather cautious and at times antagonistic attitude to the psychoanalytic treatment of the psychoses. Eventually, and partly because of the enthusiastic persistence of some of his students (like Abraham and Federn), Freud

accepted that psychoanalysis could be applied to psychotic patients, provided that certain technical modifications were introduced. At any rate, even in the case of the treatment of the psychoses (and this is valid to this day), if we speak of *psychoanalytic* treatment it is because there are ethical and technical principles that are common to the treatment of any patient by a psychoanalyst. To put it briefly, psychoanalysis is in any case an experience of discourse which occurs within the field of language and which utilises speech as a medium, where the patient's verbal production (or its equivalent) constitutes the subject-matter of the clinical work. This consists essentially in the analyst's listening attentively to what the patient says in order to help him to decipher that production and thus learn from it. Even if we take into account the modifications required by the treatment of the psychoses, it would appear that in psychoanalysis the clinical method is more important than the diagnosis; that, unlike certain contemporary developments in the different therapeutic approaches, where the prevalent notion is that a specific technique should be applied to each particular disorder, in psychoanalysis the same method is basically applied to any problem brought to the consultation: 'Tell me whatever goes through your mind'—the implicit message transmitted by the analyst being: 'If you speak without thinking about what you say, you will end up saying something that you never expected to say. That is a knowledge that concerns you and nobody else; it is a knowledge of vital importance to you, as it refers to your desires and the secret forms of enjoyment that you have and of which you are not aware.' It is this promise of knowledge to be produced through free association that keeps the analysand going.

The Freudian method enables us (analysts as well as analysands) to learn about realities which are strictly *singular*, unique and irreproducible. Although in psychoanalysis we work with categories which are *universal* and also with *particular* cases (for example, with the categories of hysteria and obsessional neurosis and with particular cases of hysteria and obsessional neurosis), our efficacy concerns a singular subject, historically unique and individually equal to nobody else. Aristotle (in *De Interpretatione*) had already distinguished between the three categories of the universal, the particular and the singular, making of the singular a category different from the other two but retaining a property of each of them: singular is the individual which constitutes a class (like a universal), but a class of its own, a class with only one member. In psychoanalysis we work with singulars. (Cf. Lacan's discussion of the singular in *Seminar IX* [Lacan 1961-62; in particular, the seminar of 21 February 1962]; also Kant 1929, 104 foll.; 168 foll.)

Diagnosis, therefore, involves a tension between categories of universal application (hysteria, paranoia, etc.) and cases, which are cases *of* … (hysteria, paranoia, etc.), but treated in such a way (*one by one*, as Lacanians used to say) that no case is interchangeable. At this point we face a logical problem: a diagnostic system which had as many categories as patients would be entirely useless. On the other hand, the application of diagnostic categories to individual subjects as is routine in, say, the treatment of infectious diseases, is not the best model for the psychoanalyst. It is true that the specialist in infectious diseases has to take into account the particular conditions of the patient; for example, that the patient may be allergic to Penicillin, in a situation where Penicillin is the treatment of choice. But the analyst, in the first place, has to deal with a much larger number of variables; and secondly, the analytic 'material' is not objectifiable in the same way as, say, a virus or a bacterium. The analytic 'material' is objectifiable in so far as it is made of tangible objects, the patient's verbalizations. But these verbalizations refer to realities which are not present in the perceptual field in the same way as the spoken words. I refer to

what Lacan called ‘the resonances of speech’, phantasmatic realities evoked by speech, as well as holes, gaps and objects empty of contents which can only exist as a function of language.

Diagnosis in psychoanalysis involves universals, that is, terms that designate entire classes (hysteria, paranoia, Oedipus complex, drive, object *a*, etc.). These universals are finite in number, and all of them involve the work of culture and inscriptions in language; none of them refers to ‘natural’ phenomena, even in the case of terms that refer to realities that have a natural support, such as the human body. The anatomist uses universal terms to refer to the body, which is for him a physical entity. With the exception of some pathological deviations and some deficiencies, all the members of our species have bodies with the same number of organs which perform the same physiological functions; so similar are they that, within some limits, they can be exchanged. That is not the case of the body from a psychoanalytic perspective: what we call the body is not identical to the organic soma, but an imaginary and symbolic construction which is affected by the human world (a world of culture and language) in which we live. From a diagnostic point of view, the body is of paramount importance in psychoanalysis, and there is no human condition—neurotic, psychotic or perverse—in which the body is not a problem. In fact, the most common clinical problems of differential diagnosis concern the body. Consider a hysterical conversion symptom, to this day a big problem in practice, for the psychoanalyst as much as for the medical practitioner. ‘Conversion hysteria’ is a term created by Freud; it designates the moulding of organs and functions of the body in terms determined not by nature but by the language that surrounds and gets inserted into the subject’s body. In conversion hysteria, the bodily symptoms *resemble* the somatic symptoms of the different organic illnesses, not according to the physiological laws that govern the organic body, but according to the words of popular language that literally name the organs and functions affected. That is why conversion symptoms adopt rather absurd forms which have gained for the patients that suffer from them the reputation of being malingerers: hysterical pregnancies, hysterical paralyses, anaesthesias, blindness, deafness, etc. These conversion symptoms are strictly determined by the discourse of the Other (the unconscious is the discourse of the Other, according to Lacan’s definition), and that is why their form varies from culture to culture and from language to language. In Spanish-speaking countries, for example, conversion symptoms involving the liver are frequent, while they are rather rare among English-speaking hysterics. This has to do with the linguistic fact that the liver is in Spanish regarded as the site of certain human passions that often emerge in everyday drama. One says in Spanish, literally, ‘*Me pateó (en) el hígado*’ (‘He [‘she’ or ‘it’] kicked me in the liver’), as one says in English ‘a pain in the neck’ and similar expressions.

In fact, a positive diagnosis of a conversion symptom is only possible through the application of the psychoanalytic method, since it is only in the patient’s associations (the narrative of his account of the origins and evolution of his symptom) that the symptom is defined with precision and its unconscious function unveiled. It is only in the analytic discourse that the liver, for example, will show itself to have been captured by the unconscious, and made to signify, to represent the unconscious struggle between a secret desire and a counter-desire—something that normally livers do not do. Freud chose the apt term of ‘conversion’ to designate this transgression of the laws of nature on the part of the unconscious: conversion of a psychical, verbal representation onto a form of somatic representation, where the body comes to operate as a signifier, an instrument for a plastic form of representation. In normality,

the body is utilised in a signifying capacity to produce gestures (and gestures are signifiers subjected to the rules of the symbolic order). From a scientific and rational point of view, a conversion symptom should not be diagnosed by exclusion, as is sometimes done in practice when no physiological causes can be found for a somatic symptom. A conversion hysterical process is suspected in such cases. Strictly speaking, a conversion symptom can only be diagnosed positively: by uncovering the unconscious drama that underlies it.

It is not a coincidence that psychoanalysis was co-invented by Sigmund Freud and hysterics who suffered prominently by conversion symptoms: hysterics love to tell the truth (even if then they regret it), and that led to the adoption of the method of free association (Cf. the case of Emmy von N. in the *Studies on Hysteria*); and they also talk with their bodies, and this led, in Freud's experience, to the deciphering of the unconscious statements contained in conversion symptoms.

3 The logical moments of the treatment: preliminary interviews ('moment of seeing'), development of the transference ('time for understanding'), ending of the treatment ('moment of concluding')

A psychoanalytic treatment must have a direction: psychoanalysis is not a 'non-directive' therapy; it has—it must have—a direction. This direction involves a policy (the ethical and clinical principles that guide our work), a strategy (the first level of implementation of the policy, which essentially concerns the handling of the transference) and tactics (the concrete interventions, interpretations and other acts that the analyst produces). The question of diagnosis concerns fundamentally the first two levels, the tactical movements of the analyst being subordinated overall to the policy and strategy of the treatment.

At the same time, we can recognise three logical moments in the treatment, which correspond to the three moments of logical time as described by Lacan: 1) The *moment of seeing* (or rather, listening in the case of psychoanalytic treatment), represented by the *preliminary interviews*, where the first diagnostic hypotheses on the part of the analyst are produced; 2) The *time for understanding*, which corresponds to the *entry into analysis and the development of the transference*, the central and more extended phase of the treatment, where the working-through of the unconscious as Freud described it takes place; and 3) The *moment to conclude*, or *ending of the analysis*. (Lacan 1966, 197) This is rather schematic, as the concept of logical time and its different moments can also be applied to each of the segments of an analysis (a single session, for example, or the preliminary interviews as a whole).

The expression 'preliminary interviews' is Lacanian and corresponds approximately to what Freud called a 'trial period' of analysis. (Freud 1913c, 123-5) Freud considered that a trial period could be offered to those patients who do not appear to have made up their minds about having an analysis—as distinguished from those who are resolute in their decision from the beginning. Lacan was not convinced that the patient is determined to have an analysis from the start, and proposed that there should always be preliminary interviews, with the functions of making the patient become familiar with the psychoanalytic method, of facilitating the development of the transference and of formulating a diagnosis. He apparently recommended (this is oral tradition; I do not have a written reference for it) that several preliminary interviews (at least three) be conducted before inviting the patient to commence an analysis. It is a good idea, according to my experience, to have these interviews at different times of the day and very frequently, so as to become immersed in the patient's life and style as much as possible. A number of patients

never progress beyond the preliminary interviews, and some stay in treatment for years without entering analysis 'proper'.

This leads us to the question of what is analysis 'proper'. The matter is highly relevant to the problems presented by diagnosis. In this context, 'proper' should be written between inverted commas: we do not have a precise canon that would satisfy every psychoanalyst as to what constitutes psychoanalysis as a clinical experience.

The question of the entry into analysis concerns the criteria that we employ to establish whether a patient has entered the analytic discourse and has therefore become an analysand. 'Patient' is someone who suffers, and suffering is a necessary but not a sufficient condition for analysis. 'Analysand' is the patient who analyses, who wants to learn about his suffering and not simply enjoy it. The entry into analysis may take a few interviews or a few years; it may never happen. A common factor in these three situations is that we can *never* say beforehand, before doing some work with the patient, whether somebody is analysable or not. This concerns, in turn, the questions of analysability (or who can be analysed) and of indications and contraindications for analytic treatment (in what cases can psychoanalysis be positively recommended, and in what cases it is not indicated at all and could cause more damage than good). Some psychoanalysts have advocated for the application of clear criteria for analysability prior to the encounter with an analyst—criteria to be employed by generalists, psychiatrists, psychologists or other professionals and based on objective, external parameters. Our experience shows that this is not a rational way to deal with the problem of whether the patient is going to benefit from analysis or not. This can only be tested on a one-to-one basis and in person. The fact that hysterics co-invented psychoanalysis and that many hysterics have done well in their analytic experience does not mean that psychoanalysis can be recommended without further consideration to all hysterics; and we know of a few abysmal failures of hysterics in analysis. The fact that psychoanalysis has not been terribly efficacious with many perverts and quite a few psychotics does not mean that it should be contraindicated for perverts and psychotics (and I say this *against* certain remarks made by Freud himself regarding contraindications of psychoanalysis); and, again, we know of quite a few remarkable successes in the psychoanalytic treatment of psychotics.

4 Diagnosis within the transference: the symptom 'joining in the conversation'

For Freud, it is the establishment of the transference that marks the beginning of the analyst's work of interpretation. (Freud 1913c) This conception led Lacan to say that "at the beginning of psychoanalysis, there is transference', a statement that is open to interpretation. Freud deduced from his own experience that the analyst's interpretation is effective only if the patient's unconscious is engaged in the relation with the analyst and the treatment; or, to put it in another way, if the analyst becomes an object for the patient and a significant component of the patient's unconscious. The development of the transference is possible because the analyst's stance is from the beginning an interpretative one: the analyst himself engages in an operation of wanting to know more of the story that the patient tells and of deciphering his words from the outset. This is the manifestation of what Lacan called the analyst's desire, without which there is no development of the transference; at least, no development of the transference that is useful for the patient.

How do we know that the patient is engaged in the work of analysis, that he is developing a transference-relation with that work, that his unconscious through its

formations is operating in the analytic dialogue, engaging both patient and analyst in this dialogue? The best indicator of such engagement seems to be that a symptom of the patient enters the scene, and thus offers itself for analysis. In his early work, the *Studies on Hysteria*, Freud referred to this crucial moment of an analysis as the symptom 'joining in the conversation'. (Freud 1895d, 148, 296-7) This exposure of the symptom enables its analysis: the reconstruction of its history and the deciphering of the cryptic, secret inscription and signification that the unconscious dimension of the symptom contains. For the symptom is a rather autistic formation, an a-social form of jouissance. If Lacan could say of human desire that it is always the desire of the Other, the same *cannot* be said of the symptom: my symptom does not bring you any enjoyment, secret or manifest; your symptom does not do anything for me. When the symptom is brought up in the analytic dialogue, it loses its autistic, antisocial quality: for the first time, it becomes socialised, and that is how it starts to lose its jouissance-value (if you allow me this expression). In Freud's terms the symptom—which is a formation of the unconscious alongside the dream, the parapraxes, jokes and the verbalizations of the analysand who follows the rule of free association—is also 'the sexual life of the neurotic', that is, his secret libidinal investments and a form, however aberrant, of satisfaction. That the patient brings the symptom for analysis constitutes a solid indication that he means business, that the unconscious is engaged in the analytic operation, that is, in the transference-relation. It also means that the subject of the unconscious is prepared (despite himself, one could say) to surrender the symptom, as the enjoyment that the symptom provides reveals itself to be destructive, crippling and mutilating in relation to other possible forms of enjoyment that the subject could have.

A patient of mine presented with a classical version of astasia abasia (a sudden feeling of weakness in the legs and the sensation of falling down), which analysis revealed was set in motion by the words of her mother, 'You shall always need a crutch'. It was only then that she realised how consuming her symptom was: she always needed someone 'to lean on'—she needed to take one of her children with her when she went out, and literally used him as a crutch, leaning upon his shoulder; and on a few occasions she fell on top of me as I opened the door of the consulting-room; she always needed to consult somebody before taking the most trivial decision, and similar measures which effectively caused serious restrictions and privations in her life. Her bringing the symptom into analysis revealed the secret, masochistic satisfaction that it unconsciously provided, and also its cost: crippling effects at different levels of the patient's life.

The question of the emergence and treatment of the symptom takes us to the problem of the status of the symptom in psychoanalysis. As already pointed out, psychoanalysis has made of the symptom a production and does not consider it merely as a deficit. Its therapeutic value resides precisely in transforming the symptom into a source of knowledge, an opportunity for research into one's desire and sources of jouissance, instead of retaining it as a form of enjoyment and a source of hatred of self and others.

Freud conceived of the neurotic symptom (conversions, obsessions, compulsions, phobias, neurotic inhibitions) as, on the one hand, a formation of the unconscious, and on the other a relatively permanent form of unconscious libidinal satisfaction, albeit distorted, which to consciousness appears as a dysfunction accompanied by suffering. As a formation of the unconscious, the symptom reveals a symbolic structure which follows the same mechanisms (condensation and displacement for Freud; metaphor and metonymy for Lacan) found in the production

of dreams, jokes and parapraxes. As the sexual life of the neurotic, the value of the symptom is not so much as a symbolic formation but as a real jouissance. As a real thing, the symptom has permanence (as contrasted with the transient nature of dreams, parapraxes and jokes); the symptom is there to stay, it is difficult if not impossible to remove and operates as a conservative condenser of jouissance in which we can recognise the death drive, as it does not do anything to preserve the living organism—on the contrary. In this sense, the symptom should be considered outside the formations of the unconscious. Freud spoke of these formations as *compromise* formations (the expression 'formations of the unconscious' was coined by Lacan: Lacan 1998); and the symptom is characteristically *uncompromising*, non-dialectical, rigidly demanding. It is certainly possible to learn from it, but its therapeutic resolution requires a further step, the re-direction and re-organisation of the subject's modes of jouissance away from it, away from the mutilating imaginary and real damage that it entails.

Lacan called 'formal envelope of the symptom' this process during which the symptom, a secret even for the subject who suffers from it, becomes a social entity, an ingredient of discourse, expressed—for the first time—in the language of the Other, and therefore open to the influence of the Other through discourse. (Lacan 1966, 66) The ethical and legal status of the symptom changes, as it leaves its clandestine state to become the subject-matter of the analytic dialogue. This process has been compared with the reporting of an anomaly or crime to the authorities: while the subject knows about the crime without telling anybody, he may complain about it without any tangible effect and one can say that he is an accomplice, or an accessory to the crime. When the subject decides to report the fact that had been kept in the dark to the authorities—the police, or the court—he is forced to do so employing the language of the Other, so as to become intelligible. This is analogous to what happens in analysis with the bringing of the symptom into the conversation: the patient has to make an effort to make himself understood, and in doing so something else happens: he discovers new things about his symptom that in its previous clandestine state were hidden.

Freud says in his introduction to the case of Dora that the hysterical patient is particularly vague about the description of his symptoms. You ask him where is it exactly that he feels his pain, and he responds: 'Well, somewhere there, below the neck, to the left or the right of the abdomen; or perhaps it is not just there'. –'And at what time of the day does it appear?' –'Well, generally late at night, although most days also early in the morning, and today I think it will be in the afternoon.'

Freud also says that experience shows that when the symptom shows up in analysis there is usually an exacerbation of its effects: it becomes more prominent and noticeable in the life of the subject—the pain becomes more acute, the anguish more excruciating, the inhibitions more crippling—until there is a resolution, and the subject decides to dedicate his efforts to causes other than his symptom. It proceeds, Freud argues, as the child who is reprimanded and stops misbehaving, but not without repeating his naughty conduct one more time before surrendering.

The efficacy of psychoanalytic treatment, therefore, depends on the integration of the symptom into analytic discourse and the transference-relation that this discourse promotes. One talks about one's symptom ('the most real thing one has', says Lacan) to somebody one trusts; more specifically, one trusts that the analyst will be instrumental in producing the knowledge necessary to understand and explain one's symptoms and find a way other than the symptom to be happy.

Implicit in all diagnostic construction in psychoanalysis there is what Freud called 'the fundamental rule for the psychoanalyst'—the rule of 'free floating attention', or of abstaining, not only from attempting to direct the life of the patient, but also from trying to understand too much too soon. (Freud 1912e, 111-113) Lacan thought that such a stance on the part of the analyst requires the engagement of what is most intimate in the analyst—his desire. Thus, Lacan introduced in psychoanalysis the concept, unprecedented in its history, of the *analyst's desire*, a desire that allows for the respect of the singularity of the patient and the analyst's abstaining from promoting identifications in the patient: the identification with the analyst himself or with any of the diagnostic categories that the analyst may favour. (Lacan 1977; 1992; 2002)

5 Freud's categories

Freud discovered early on that not all patients engage in analytic discourse with the same facility as the hysterics who did so much for the creation and development of psychoanalysis. Some patients do not engage in the operation at all, despite the analyst's and their own efforts. On the basis of this distinction between those patients who are capable of developing a transference-relation and those who are incapable of it, Freud proposed a major diagnostic classification, which contains two categories, each of them including subcategories which are of clinical importance but which do not alter the basic dichotomic classification. I emphasise the fact that Freud's nosological categories are derived entirely from the analytic clinical experience, which is an experience of transference or at least of attempted transference. They do not derive from the application of criteria or variables external to the analytic experience, such as the observation of 'objective' behavioural indicators without an engagement in discourse on the part of the patient and the clinician.

On the basis of whether the patient develops or not a transference relation with the analyst, the two categories proposed by Freud were the *transference (psycho)neuroses* and the *narcissistic (psycho)neuroses* or *psychosis*. (Freud 1915c; 1915e) These two categories cover almost the whole spectrum of psychopathological states, if we leave aside those conditions which, although they present disturbances in psychical functioning, have a clearly defined organic aetiology (such as the toxic and other organic psychoses). In addition, Freud used two other categories: the actual neuroses and the perversions.

We cannot speak, however, of a clearly established, comprehensive Freudian nosology. Freud held firm views on the aetiology and pathognomonic signs and symptoms of the psychoneuroses and the perversions, but was not so definitive in relation to the psychoses. It is possible to argue, as Lacan has done, that one can identify definite hypotheses in the works of Freud that justify the distinction between what Lacan called the three Freudian clinical structures—namely, the neuroses, the perversions and the psychoses. These are not merely categories of the 'pathological', but three different subjective positions, three ways of being-in-the world. The use of the term 'structures' by Lacan emphasises that the Freudian approach involves the identification of three discreet mechanisms of symptom-formation, each of them specific for every psychopathological organisation and resulting in symptoms and signs that are characteristic of each of the three structures. The Freudian texts are clear as to the constitutive function of *repression* (*Verdrängung*) in the case of the neuroses and of *disavowal* (*Verleugnung*) in the case of fetishism that he takes to be the model for all the perversions. In the case of the psychoses, Freud maintained from very early (from 1894 date of publication of his first paper on the neuro-psychoses of

defence [Freud 1894a]) that the mechanism responsible for the production of their typical clinical manifestations (delusions and hallucinations) must be different from repression. The idea of a form of rejection of psychical formations more radical than repression reappears in his study of President Schreber and in other papers. He used, although not consistently, the term *Verwerfung* to designate such a mechanism. This is the term that Lacan then proposed to translate (in French) as *forclusion* (English *foreclosure*). (Lacan 1993, 310-323)

To complicate matters, in 1924 Freud proposed to distinguish what he then called 'narcissistic psychoneuroses' from the psychoses proper, reserving the first term for melancholia and related clinical organisations, and the term 'psychoses' for paranoia and schizophrenia. (Freud 1924b) For some time he attempted to promote the use of the term 'paraphrenia', in preference to 'schizophrenia' (coined by Bleuler in 1911), but he did not succeed in establishing it, and ended up employing the term 'schizophrenia' himself, despite his dislike for it. (Cf. 'Paraphrenia', in Laplanche and Pontalis 1973).

Freud created new diagnostic categories and reformulated a number of the already existing nosological entities. Evidently, the advance of clinical knowledge results regularly in the invention of new categories. A structural (as distinct from a descriptive) approach puts a limit to the accumulation of nosological categories by identifying underlying mechanisms common to different clinical presentations. In fact, it is misleading to oppose a structural point of view to a descriptive perspective in psychopathology. This is because correct descriptions are subordinated to relevant structural hypotheses: without some reasonable hypotheses about what should be observed and how, descriptive accounts of observable phenomena are too restricted and deceptive. Before inventing psychoanalysis, Freud approached the clinical phenomena of hysteria already with some hypotheses in mind. He did not observe or listen to just anything and everything, but was selective within his field of observation and excluded a considerable number of variables. As a clinical practice, psychoanalysis is very much an empirical discipline. But the experience in and with which it works is not a 'natural' one; it is an artificially organised discourse that provides a frame for the study and treatment of unpredictable real phenomena.

Apart from the categories of transference and narcissistic psychoneuroses, which he used after the introduction of the concept of narcissism, during the first years of psychoanalysis Freud had already proposed a number of diagnostic terms which we continue to use to this day: conversion hysteria; obsessional neurosis; actual neuroses (which include neurasthenia and anxiety neurosis—not to be confused with anxiety hysteria), that he opposed to the psychoneuroses (hysteria and obsessional neurosis, that is, the neuroses which have a historical, or infantile, aetiology); and anxiety hysteria (characterised by the production of phobias. In the field of the psychoses Freud retained the psychiatric terminology of his time.

6 Borromean clinic: R S I

I have mostly followed Freud's trajectory, which we still pursue, although reviewed from the viewpoint of Lacan's contributions. Lacan's elaborations on diagnosis would take years of seminars. I will only briefly address the question of what has been termed 'a Borromean clinic', after the topological model of the Borromean knot used by Lacan in his seminars and writings of the 1970s. (Lacan 1975-76; 1976-77)

Lacan's emphasis on the need to return to Freud in psycho-analysis—which was his manifesto of the 1950s—emerged at the same time as his original proposal of the necessity to distinguish between three, and not just two, *registers* of the subject's

experience: the symbolic, the imaginary and the real. It was precisely this distinction, and particularly the different modes of organisation and functions of the symbolic and the imaginary registers (or *orders*) of experience that led him to propose some clear and distinct hypotheses on the three clinical structures which for Lacan cover the field of psychopathology—or at least the field of psychopathology as it is accessible to the psychoanalytic experience.

At the beginning Lacan stressed the subordination of the registers of the imaginary and the real to the symbolic order, which is the order of language and of the human law. Throughout the 1960s and 1970s, however, he stressed the importance of the register of the real, and eventually proposed that the three registers have the equivalent weight and necessary interdependence. This change of emphasis resulted in some new ideas on the treatment of the psychoses, about which Lacan had proposed in the 1950s an original theory with a particular hypothesis on the mechanism of production of psychotic phenomena (delusions and hallucinations). (Lacan 1993) The matter is of direct practical significance, as in psychoanalytic practice, at least in Australia, we deal more and more with psychotic patients and with new forms of the clinical presentation of psychosis.

7 Diagnostic problems

To conclude, let me say a few words about the most common diagnostic problems that we face these days. I say 'these days', and this evokes a common notion currently according to which the clinical pictures adopted by the psychopathologies of our contemporary world have changed radically. The structural method employed in psychoanalysis helps to put things in perspective. We can safely say that the psychoanalytic method permits a more rigorous and thorough analysis of the patient's presenting complaints, signs and symptoms; of the functions that the symptoms serve, unconsciously and even consciously, for the subject; of the reasons why the patient attaches himself to the symptom so obstinately and why he has always chosen the worst possible forms of treatment to deal with it. The work of analysis makes of the patient an analyst who investigates his own life and works.

We have to respect the capacity that human beings have to develop new pathological forms. But we also have to be cautious, so as not to be seduced by bizarre, original manifestations of madness. Once under scrutiny, these new pathologies start to show the same old tricks of the classic neuroses, perversions and psychoses. Then there are what we could call the 'unclassifiable', the really problematic clinical presentations. The most astute and experienced clinicians have had at least once the experience of, say, the sudden eruption of a psychosis in a patient that presented as a classical hysteric; or—in the other direction—the clinically unexplainable improvement of a typical psychotic, who abruptly decides to become normal.

The matter is complicated, no doubt, by the pervasive influence of contemporary psychiatric discourse—increasingly subservient to the present modalities of the capitalist discourse—on all clinical practices in the field of mental health. I refer, for example, to the promotion of clinical phenomena like depression, or the so-called 'obsessive-compulsive' and 'eating disorders' to the rank of nosological entities in their own right. It is normal, from a scientific point of view, that new, specialised categories emerge as clinical research progresses: new knowledge promotes the birth of new terms and concepts. But the contemporary promotion of the categories mentioned above and other entities have less to do with scientific research than with the expansion of the psychopharmaceutical industry,

always interested in highlighting the existence and dangers of illnesses that, curiously enough, can now be treated efficaciously with certain biochemical agents.

Finally, just one word on the *temporal* dimension in diagnostic matters. If a structural approach in diagnosis leads us to emphasise a *synchronic* view of the patient, let us not forget that patients are historical beings who evolve *diachronically*. Despite their rigidity and conservatism, most psychopathological organisations develop and change throughout time, and only some essential structural components remain constant. This is more apparent in working with children and adolescents, but it is also important in the case of adults.

If the case histories of Freud remain the model for learning about the different clinical structures, and if he was a master in describing 'clinical pictures' (as we colloquially call them), that is, synchronic presentations, he was also masterly in reporting their history and the evolution of the patient's state and circumstances. If somebody presents as clearly psychotic one day but not the next day, we must take into account both facts, although this may complicate *our* lives and induce uncertainties.

Now, if we have chosen psychoanalysis to earn our living, we must learn to live with uncertainty.

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