Balance and Connection: Bipolar Disorder and Psychoanalysis in Psychiatric Practice

Brendan D. Kelly

Bipolar disorder comprises a pattern of symptoms characterised by disproportionate changes in mood, possible psychosis and various other symptoms at different times. Biopsychosocial management approaches often involve medication (e.g. lithium), psychological therapy (e.g. cognitive-behaviour therapy) and social interventions (e.g. social work support). Psychoanalytic contributions to the understanding of bipolar disorder have come from a range of therapists, including Karl Abraham, Sigmund Freud, Otto Fenichel and others. In recent years, emphasis has been placed on identifying the defence mechanisms most commonly associated with mania, and the relationship between pharmacological and psychoanalytic approaches to the disorder (e.g. links between lithium blood levels and mental processes). It is important that, amidst such therapeutic endeavour, and in the context of emergent neurobiological approaches, the individual’s search for meaning in their experience is not lost. Psychoanalytic approaches have a unique role in this respect. Regardless of resource challenges in public mental health services, there is a strong need for a diversity of approaches to all mental health problems, including bipolar disorder, in order to reflect the diversity of individuals affected, problems faced and pathways to recovery.

Keywords: Bipolar disorder; psychosis; psychoanalysis; therapy; lithium

Introduction: Irish Mental Health Services

A Vision for Change, Ireland’s most recent statement of mental health policy, states that ‘each citizen should have access to local, specialised and comprehensive mental health service provision that is of the highest standard’.¹ Services should be delivered through community mental health teams, each comprising two consultant psychiatrists, two doctors in training, two psychologists, two psychiatric social workers, six to eight psychiatric nurses, two or three occupational therapists, one or two addiction counsellors or psychotherapists, two or three mental health professionals, and one or two addiction counsellors or psychotherapists.

support workers, and administrative support staff.\textsuperscript{2} In addition, ‘each team should appropriate include a range of psychological therapy expertise to offer individual and group psychotherapies in line with best practice’.\textsuperscript{3}

Despite some progress on achieving these standards, there are still significant deficiencies in certain areas: in 2010, for example, the Inspectorate of Mental Health Services reported the following, in respect of one inner-city psychiatry service: ‘Each team had limited human and structural resources. The skill mix on each team fell well short of the recommended staffing levels in the national policy document \textit{A Vision for Change}.\textsuperscript{4}

Notwithstanding these deficits and challenges, the public mental health service remains the central vehicle for provision of psychological services to individuals with mental illness in Ireland, including those with bipolar disorder.

\textbf{Management of Bipolar Disorder}

Bipolar disorder is a mental illness characterised by two or more episodes in which the patient's mood and activity are significantly disturbed, and this disturbance consists, on occasion, of an elevation of mood and increased energy and activity (i.e. hypomania or mania), and, on other occasions, a lowering of mood and decreased energy and activity (i.e. depression).\textsuperscript{5} Ideally, management of bipolar disorder would adhere to the principles of biopsychosocial psychiatry, involving biological approaches (e.g. medication), psychological therapies (e.g. cognitive-behaviour therapy) and social interventions (e.g. social work support).\textsuperscript{6}

The medication used in bipolar disorder will vary, depending on the individual and the precise nature of their symptoms at any given time. ‘Mood stabilisers’ are commonly used to reduce the frequency and magnitude of severe mood swings. The classic example of this group of medications is lithium, which has a long history of use in bipolar disorder.\textsuperscript{7}

\begin{footnotes}
\item[2] ibid. pp. 95 - 96
\item[3] ibid., p 98
\end{footnotes}
There is, however, a range of other medications which are indicated for use in various stages of the disorder (e.g. depression, elation, maintenance, treatment-resistance, etc.).

In terms of psychological therapy, a range of therapeutic approaches have been used for bipolar disorder, including psycho-education, cognitive-behaviour therapy, family therapy, interpersonal therapy and psychoanalysis. Most attention has, however, been paid to cognitive and behavioural approaches. Miklowitz et al for example, examined the benefits of family-focused treatment for adolescents and pharmacotherapy in adolescent bipolar disorder, using a ‘family-focused’ model centred on psycho-education, communication training, and problem-solving skills training. Patients receiving the family-focused treatment recovered from baseline depressive symptoms faster than those who were not receiving such treatment, suggesting that family-focused therapy is effective, in conjunction with pharmacotherapy, in stabilizing depressive symptoms among adolescents with bipolar disorder.

Despite the relatively greater emphasis on cognitive and behavioural approaches to bipolar disorder at present, the contribution of psychoanalysis has also commanded significant attention in recent years.

In an early contribution to the field, Karl Abraham (1877-1925), a German psychoanalyst, characterized mania as a manifestation of what had earlier been repressed in depression, and an open expression of emotion which reflected a regression to childhood. The interpretation of material produced in the context of mania was always challenging, however: in 1917, Sigmund Freud (1856-1939) wrote that ‘we are without insight into the mechanism of the displacement of melancholia by a mania’.

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12 E. Etzerdorfer, G. Schell, ‘Suicidality in Bipolar Disorders – Psychoanalytic Contribution’ in *Archives of Suicide Research* 2006, 10, pp 283-94.
By 1921, however, Freud was expressing clear ideas on the matter, suggesting that mania resulted when the ego and ego-ideal fused together, so that the individual who is elated, ‘disturbed by no self-criticism, can enjoy the abolition of his inhibitions, his feelings of consideration for others, and his self-reproaches.’

Edith Jacobson (1897-1978), a German psychoanalyst, wrote that individuals with bipolar disorder appear to live for their ideals rather than their own egos, and mania occurs when the self continually participates in fantasies about the omnipotence of the love object. Otto Fenichel (1897-1946), an Austrian psychoanalyst, suggested that the ‘free interval’ was the best time to commence analysis in bipolar disorder, owing to ‘the narcissistic nature of the illness and the consequent looseness of the transference relationship’.

Psychoanalytic views have continued to develop in recent decades, with Lippe noting that bipolar disorder often assumes its characteristic form during adolescence, which is a time of psychic maturation and personality emergence. Against this background, the development of independence, from a psychoanalytic perspective, may be associated with a split of the identification object, loss of the invested object, and subsequent melancholy or, alternatively, the emergence of its ‘pseudo-triumphant variant’, mania.

Kramer et al place particular emphasis on defence mechanisms and studied the defence mechanisms of thirty in-patients with bipolar disorder, using the Defence Mechanisms Rating Scale (an observer-rating scale, applied to session transcripts). They found that defence specificities in bipolar disorder included a set of five immature defence mechanisms. Amongst these, omnipotence (which involves acting as if one possesses special powers or abilities) was linked to symptom level. Rockland also

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17 E. Etzerdorfer, G. Schell, op. cit.
19 Ibid., p. 413.
emphasises the role of defence mechanisms in mania, suggesting that depression is the key phenomenon and that ‘extreme use of primitive denial leads to the clinical state of mania’. Kramer et al found that mature defence mechanisms were positively linked to level of therapeutic alliance in bipolar disorder.

Loeb and Loeb\(^{23}\) link psychoanalytic and pharmacological treatment modalities in bipolar disorder, by providing systematic psychoanalytic observations on the effect of lithium on manic episodes. They observed a relationship between patients’ lithium blood levels and changes in their conscious and unconscious processes, thoughts, feelings and wishes. An awareness of this relationship may help modify and modulate treatment, and, hopefully, prevent the distressing mood swings which characterise bipolar disorder.

**The Search for Meaning**

In bipolar disorder, as in many other disorders, the individual affected often embarks on a search for meaning in their symptoms: this is an important process (Etzerdorfer & Schell, 2006). This also raises an important issue for contemporary psychiatry and psychotherapy, which need to balance the need for standardised diagnostic practices (which facilitate the assembly of therapeutic evidence) with the need for individualised treatment plans (which facilitate the individual search for meaning).

Contemporary psychiatry uses two central classification systems for describing and categorising psychiatric disorders: the *International Classification of Diseases (10th Edition)* (ICD-10) (World Health Organization, 1992) which is chiefly used in Europe, and the *Diagnostic and Statistical Manual of Mental Disorders (4th Edition)* (DSM-IV) (American Psychiatric Association, 1994)\(^{24}\) which is chiefly used in the United States. While precise criteria differ between classification systems, the overall approach does not: both systems list symptoms which are intended as a guide to assist with diagnosis. This approach has both positive and negative aspects, and much depends on how such classification systems are used and interpreted.


In the case of the DSM, there is a *Structured Clinical Interview for DSM* (SCID) which, in its assessment for schizophrenia, for example, enquires if delusions are ‘mood congruent’ (i.e. consistent with the patient’s mood) or ‘bizarre’. Both these parameters are answered as ‘yes’ or ‘no’. The content of the delusion is not explored further in any significant depth. The simple presence or absence of the delusion, and whether it is ‘mood congruent’ or ‘bizarre’, is all that seems to matter in the first instance.

This approach, if taken at its most literal, reductive level, would ignore completely the meaning embedded within a specific delusional belief. Such an approach would be regrettable: meaning is likely to matter deeply to the individual, who may be profoundly invested in discovering why they developed this particular delusion (of all possible delusions) at this particular time (of all possible times). This search for individual meaning, which can be greatly facilitated by various psychotherapeutic approaches (including psychoanalysis), does not reduce the usefulness of DSM-IV or ICD-10, but complements them, resulting in a more nuanced, dimensional understanding of the individual’s experience of psychological distress.

The psychoanalytic approach also complements recent and increasing emphasis on the neurobiology of various mental illnesses, including bipolar disorder. Neurobiology may well attempt to explain human behaviour on a different and more scientific level than psychoanalysis, but the explanation offered through psychoanalysis may often prove more meaningful at the individual level, especially amongst individuals with disorders such as bipolar disorder who are especially confused by their unusual, troubling or apparently unpredictable symptoms.

Consistent with this approach, Garfield outlines a fascinating psychoanalytic approach to the idea of ‘recovery’ by emphasising the importance of the environment in providing a ‘curative audience’, especially for recovery from psychosis (which may occur in bipolar disorder). Garfield identifies three forms of ‘curative audience’ in this situation: the initial relationship with the other, the therapeutic alliance, and the creation of an external self-object milieu as recovery progresses.

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26 S. MacSuirbhne, B. D. Kelly, ‘Vampirism as Mental Illness: Myth, Madness and the Loss of Meaning in Psychiatry’ in *Social History of Medicine* 2010, October 19 (Epub ahead of print).

27 L. H. Rockland, op.cit.

28 D. A. Garfield, ‘All the King’s Horses and All the King’s Men. Three forms of Curative Audience in the Recovery from Psychosis’ in *American Journal of Psychotherapy*, 1998, 52, pp 125-46.
and deepens. Garfield’s approach, combined with those of others,\textsuperscript{29} firmly underlines the potential role of psychoanalytic approaches in the management of certain aspects of bipolar disorder, for at least some people, in combination with other therapeutic approaches.

At present, however, there may be limited possibility for such approaches to yield their full potential in Ireland, given the resource challenges faced by Ireland’s public mental health service: in 1966, the proportion of Ireland’s health budget devoted to mental health was 23.0%; by 2007, it had fallen to 7.8%; and in 2010 it stood at 5.3%. This trend, however, combined with emergent literatures on a range of therapeutic approaches to psychological distress, simply highlights a growing need to emphasise the importance of mental health in broader society, and the need for a diversity of approaches to mental health problems, to reflect the diversity of individuals affected, problems faced and pathways to recovery.

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Psychological Object or Speaking Subject: from Diagnosis to Case Re-presentation

Cormac Gallagher

There is a common view that there are two irreconcilable approaches to the understanding and treatment of mental illness. For most of the twentieth century Freudian psychoanalysis was dominant, and many professors of psychiatry were also analytically trained. In more recent years Emil Kraepelin, who had put psychiatry on a scientific footing in the nineteenth century, has regained what many consider to be his rightful pre-eminence. But are Freud and Kraepelin incompatible? This paper proposes that some synthesis between them was achieved by Jacques Lacan, a classically trained psychiatrist with links to Kraepelin, who nevertheless demonstrated that the psychiatric case-presentation was enormously enriched by the application of Freudian methods to public conversations with psychotic patients.

Keywords: Wilhelm Wundt; Franz Brentano; Thesis-antithesis-synthesis; psychological testing.

Introduction

For Daniel Burston the ‘neo-Kraepelinian manifesto’ published by Gerald Klerman of Yale in 1978 is a major source of the plague of misdiagnosis and excessive use of drugs that he sees as characteristic of contemporary American psychiatry. Klerman called for ‘a repudiation of psychoanalytic modes of thought and practice and [placed] extravagant hopes in the powers of brain imaging and psychotropic medication to unravel the baffling mysteries of mental disorder’. Burston also argues that these neo-Kraepelinians are not as faithful to Kraepelin as they might think and that a return to his diagnostic categories would lead them to question, among

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other things, the multiplicity of bipolar diagnoses currently proposed by DSM-IV.

Now these remarks introduced me, and I suspect many of his listeners, to a novel perspective on the recent changes in psychiatric practice and the training of psychiatrists – as exemplified in the style of the case presentation – by attributing them not simply to the availability of new psychotropic drugs and the pressures of the pharmacological industry but to an ideological preference for the theories of a long-dead German psychiatrist over the familiar Freudian perspectives.

**Irreconcilable perspectives on mental illness**

But who is Kraepelin and why his return to favour in the form of neo-Kraepelianism fifty years after his death? To put the discussion in context it may be helpful to quote the short *Wikipedia* account of the man and his work:

*Kraepelin’s great contribution in clarifying schizophrenia and manic depression remains relatively unknown to the general public and his work, which had neither the literary quality nor the paradigmatic power of Freud’s, is little read outside scholarly circles. Kraepelin’s contributions were to a large extent marginalized for a good part of the twentieth century during the success of Freudian etiological theories. However his views now dominate psychiatric research and academic psychiatry. And today the published literature in the field of psychiatry is overwhelmingly biological in its orientation. His fundamental theories on the etiology and diagnosis of psychiatric disorders forms the basis of all major diagnostic systems we use today, especially the American Psychiatric Association’s DSM-IV and The World Health Organization’s ICD system. In that sense not only has Kraepelin significant historical importance but contemporary psychiatric research is also heavily influenced by his work*²

Thus, to contemporary psychiatry, Kraepelin and Freud offer two apparently irreconcilable approaches to the understanding and treatment of

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² Emil Kraepelin – *Wikipedia, the Free Encyclopedia*. 20/7/2011
mental illness. However, I will argue that the dichotomy implied in Klerman’s paper, and in this popular internet description, between psychoanalysis and classical psychiatry, is false and that the current poverty of psychiatry and isolation of psychoanalysis may be remedied to some degree by considering them as thesis and antithesis between which a fruitful synthesis is possible.

Concrete examples of such a synthesis are hard to find but I believe it was realised in the work of Jacques Lacan and so before discussing the twin approaches of Freud and Kraepelin I will present some aspects of Lacan’s early formation that are unknown to contemporary psychiatrists and generally neglected by English-speaking psychoanalysts.

‘Then came Kraepelin’

Even though Lacan is principally known as a controversial psychoanalyst who spent his life promoting a return to Freud, he introduces himself in his Ecrits, published in 1966, as ‘a doctor and psychiatrist’ whose medical thesis was based on an exhaustive clinical study of thirty cases of paranoid psychosis and who saw the great Gaëtan de Clérambault as ‘my only master in psychiatry’. He goes on:

Clérambault knew the French tradition well, but it was Kraepelin, in whom the genius of the clinic had been brought to its highest point, who had formed him.

The Lacan-Kraepelin link was thus well established by the time he made his public entry into psychiatry at the age of 31 with a doctoral thesis ‘On paranoid psychosis as it relates to personality.” Even though he does not appear to have been directly concerned with the bipolar, or manic-depressive, aspects of Kraepelin’s explorations, Bernard Toboul has highlighted his respect for Kraepelin’s work in general and for his frequently re-edited psychiatric text book:

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'Then came Kraepelin’ (Lacan, 1932, p.23). Emil Kraepelin succeeded in imposing differential diagnoses in the field of psychosis, where previously the category of paranoia had been extended to every kind of delusion and cognitive disorder...Lacan wrote in glowing terms of Johannes Lang, co-author of the 1927 edition of Kraepelin’s Manual of Psychiatry..., endorsed Kraepelin’s inclination towards a psychogenetic conception of paranoia, and what Lacan called ‘psychogeny’ became a main theme of his thesis. Hence Lacan’s harsh criticism of organicism, the constitutional theory, and the ideology of degeneracy – all then still prevalent in French psychiatry.

Lacan thus stakes out his claim to be a classically trained psychiatrist in the great French and German traditions, a position he would maintain until the end of his life with his questioning, for example, of the mental state of James Joyce and his daughter in the seminar on the Sinthome (1975-76).

**Freud: From the illness to the patient**

But in his thesis Lacan also declared his conviction that Freudian psychoanalysis went beyond the undoubtedly valuable observations of other theories – including Kraepelin’s - in grasping the true nature of pathology. In the 1966 reflections quoted above he continues:

> Strangely, but necessarily, I believe, I was led to Freud. For fidelity to the formal envelope of the symptom, which is the true clinical trace for which I was getting a taste, led me to this limit where it [the symptom] reverses itself into creative effects.

These elliptical remarks may perhaps be clarified by Lacan’s earlier statements in *The Family* (1938) where he points out that what was novel and distinctive in Freud’s approach to psychological pathology was his focus on the patient rather than the illness. This allowed him to see the symptom not simply as the product of objective neurological processes but

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5 Bernard Toboul, *Aimée, Case of*. www.enotes.com/psychoanalysis-encyclopedia/aimée-case 20/7/11

as a subjective creation devised in the face of an individual drama to save the individual from slipping into an existential abyss:

Freud’s discovery of the complexes was revolutionary because as a therapist more interested in the ill person than the illness, he was attempting to understand him in order to heal him and, further, because he interested himself in what had been neglected as being simply the content of the symptoms, but which was in fact the most concrete aspect of their reality, so that he examined the object that had provoked the phobia, the somatic system or function involved in hysteria, and the representation or affect preoccupying the obsessional subject.7

We will return to Lacan later and in particular to his practice of the psychiatric case presentation – derived from Kraepelin - in which he demonstrated the fruitfulness of the speech of psychotic patients in the search for an understanding of basic psychoanalytic positions.

**Kraepelin and Freud: thesis and antithesis**

This may be an appropriate place to discuss briefly the paths taken by these two great founders of modern psychiatry whose work, as we have seen, found something of a synthesis in Lacan. It is this example of synthesis which suggests that, rather than seeing their two approaches as running along parallel tracks, we might consider Kraepelin with his experimental objectivity as elaborating the fundamental thesis on which scientific psychiatry was established and on which it is today trying to build. And Freud with his introduction of the unconscious and the central place of the speaking subject setting up an antithesis which contemporary psychiatry seems determined to reject as unscientific and even harmful.

Curiously both men were born in the same year and received a very similar 19th century style German medical education but, as we shall see, the clinical genius of each of them expressed itself in very different ways. Both Kraepelin and Freud were trained neurologists and neuro-anatomists who in their 20’s went to Paris to study with Charcot, then the

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acknowledged leader of the field in France. But whereas Freud was to embrace Charcot’s hypnosis as a tool for therapeutic work, Kraepelin, after a brief flirtation, soon came to reject it as unscientific and as a form of suggestion that interfered with the doctor’s objectivity.

Emil Kraepelin (1856-1926) – The founding thesis of scientific psychiatry

For a comprehensive account of Kraepelin’s life and work, especially as it relates to Freud’s, I refer the reader to Tom Dalzell’s recently published and highly praised thesis.8 The following account is in large part derived from this work.

Kraepelin was born in the German town of Neustrelitz, and when he began his medical studies in Leipzig in 1874 he immediately fell under the influence of the great Wilhelm Wundt, the founder of modern experimental psychology, and began to apply his then revolutionary approach to the problems of mental illness:

Against theologizing metaphysical psychology on the one hand, and uncritical somatic brain mythology on the other...Wundt’s version of psychophysical parallelism offered Kraepelin a foundation for his own approach, and psychophysical experiments became for him the indispensable means of researching mental phenomena...9

Kraepelin then was far from being the pure neurologist presented by contemporary neo-Kraepelinians. He saw himself as a ‘psychologically inclined psychiatrist’ and, in what is often seen as the most fruitful period of his work in Heidelberg, he followed Wundt in setting up laboratories to study the measurable psychological reactions of his mental patients. In this he was in tune with the university psychology that was beginning to flourish in the early 20th century, and to find applications in the cognitive and affective assessment of a whole range of individuals - from schoolchildren, through military personnel to industrial workers.

8 T. G. Dalzell. Freud’s Schreber between Psychiatry and Psychoanalysis: On Subjective Disposition to Psychosis, London: Karnac, 2011.
9 ibid., p.128
To establish psychiatry on a scientific basis required the application of the method that had been so successful in the physical sciences: accurate observation, the formation of hypotheses, the verification of these hypotheses and the drawing of a final conclusion, or at least a tentative conclusion, so that the science could move on. This form of psychology has little interest in the personal histories or subjective reactions of individuals and in Kraepelin’s case did not involve a focus on the individual subject but on the features of the illness as an autonomous objective entity which followed its own laws and was independent of the subjective experience of the patient. This allowed him to continue his research in his first university posting in present-day Estonia even though he could not directly communicate with his patients in their language nor they with him.

It is also reflected in the manner in which he conducted his case presentations which set the tone for those of contemporary psychiatry. Speaking of a patient who is present but not invited to speak Kraepelin says that in some letters he has sent to his doctor he expresses: “...all kinds of distorted, half-formed ideas, with a peculiar and silly play on words...He begs for ‘a little more allegro in the treatment’....and ‘nota bene for God’s sake only does not wish to be combined with the club of the harmless’”.

Then as now it was considered a waste of valuable time for the psychiatrist to show an interest in such utterances! Enough to recognize that they are signs of dementia praecox and to take the appropriate steps – which in Kraepelin’s day were very restricted in terms of treatment.

Kraepelin’s great achievement lay in the field of the classification of psychotic illness, in particular the crucial distinction between dementia praecox (schizophrenia) and manic-depression (bipolar affective disorder). Already at 27 he had published a Compendium of psychiatry but he is best remembered for the Lehrbuch, a psychiatric textbook constantly revised in the light of his experiments and hospital work, which ran through 11 different editions between the 1890’s and 1927. Lacan, as we have seen, praised it as reaching the highest point of clinical excellence.

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10 E. Kraepelin, Lectures on Clinical Psychiatry, revised and edited by Thomas Johnstone, William Wood, New York, MDCCCCIV. I am grateful to Dr Tom Dalzell for drawing my attention to this text.
What his therapeutic approach was remains obscure to me. He is mentioned in some internet sites as the father of psychopharmacology and he was certainly aware of the harm caused by alcohol and other addictive substances. But until the late 1940’s or early 1950’s there were no specific drugs available to treat specific illnesses, and the psychiatrist’s arsenal, it has been said, contained little more than sedatives to control patients in asylums and nerve tonics to keep them out of them. Kraepelin too, I am assuming, was limited to these methods. Freud in one of his technical papers makes the devastating remark that misdiagnosis was of little importance to the clinical psychiatrist of his time because he ‘...is not attempting to do anything that is of use, whichever kind of case it may be’.11

Freud’s own approach to diagnosis was that of a therapist trying to assess the suitability of the patient for psychoanalysis. This, he argues, cannot be achieved by any sort of objective testing – cognitive tests and personality tests like the Rorschach were already available - but only by inviting the patient to speak over a period of a few weeks and forming one’s own subjective sense - forged and sharpened by years of personal analysis, supervision and clinical experience - of his mental state and his capacity and willingness to do the work required.

**Sigmund Freud (1856-1939) – The speaking subject as antithesis**

Although Freud worked for many years as a neurologist, using the scientific laboratory methods outlined above, and published extensively in the field, the financial problems that led him to abandon laboratory work put him into direct contact with patients suffering from nervous illness. Initially using hypnosis, as it had been developed by Charcot and Breuer, to uncover and abreact the traumatic memories that underlay the patient’s symptoms, he was led to the discovery of a new style of investigation and therapy: the free association which is perhaps best and most succinctly described in WH Auden’s poem:

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\text{He wasn't clever at all: he merely told} \\
\text{The unhappy Present to recite the Past} \\
\text{Like a poetry lesson till sooner}
\]

Or later it faltered at the line where

Long ago the accusations had begun,
And suddenly knew by whom it had been judged,
How rich life had been and how silly,
And was life-forgiven and more humble.

Able to approach the Future as a friend
Without a wardrobe of excuses, without
A set mask of rectitude or an
Embarrassing over-familiar gesture.  

This ‘talking cure’ based on the patient’s own observation of what was on the surface of his consciousness and his uncritical communication of it to the analyst, allowed Freud access to the material the Lacan would later describe as formations of the unconscious: dreams, slips of the tongue, jokes and memories of early sexual life. And, even if Auden’s account of the way the sudden uncovering of a traumatic memory leads to a cure may be overly optimistic, the therapeutic effects of a properly conducted psychoanalysis have been repeatedly verified – though not in a way that is open to the methods of objective psychological testing.

Kraepelin, as we have seen, had also visited Charcot and used hypnosis for a time but he became extremely distrustful of psychoanalysis, refusing to see it as anything more than a form of suggestion based on the personality of the therapist. This offended his ideas of scientific objectivity but in his criticisms he ignored that Freud too considered his work to be scientific and the required objectivity of the psychoanalyst. The analyst Freud wrote in one of his technical papers, should model himself on the detachment of the surgeon. And he insisted on a personal formation that would allow the analyst to conduct an analysis without getting personally involved in the emotions of the patient.

Freud’s practice, once he had discovered psychoanalysis, of publishing single case- histories like Dora and the Ratman to illustrate his theory and

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technique, also appeared to Kraepelin to be distinctly unscientific and a throwback to the romantic psychiatry of pre-Wundtian psychology. As we have seen he was convinced that a mental illness took its own course independently of the experience of the patient and the interventions of the therapist and therefore saw no point in attempting to uncover repressed traumatic memories. In fact, he was convinced that such procedures could be damaging to the patient – a position still held by many contemporary psychiatrists.

**Freud and Franz Brentano**

Whereas it was Wundt who inspired the young Kraepelin, in Freud’s first years at the University of Vienna his imagination was fired by Franz Brentano, a liberal Catholic ex-priest and author of the epoch-making *Psychology from an empirical standpoint*. Published in the same year – 1874 - as Wundt’s *Principles of physiological psychology* this work, with its stress on human intentionality, laid the basis for phenomenological psychology which, though popular on the continent, has had little influence in the English-speaking world. Brentano had come from Prague to Vienna to teach at the Faculty of Philosophy and his lectures captivated Freud. In November 1874, just as Kraepelin was discovering the experimental methods that would determine his future career, he wrote to his friend Eduard Silberstein:

*I should be very sorry if you, studying law, entirely neglected philosophy while I, the godless empirical man of medicine, attended two philosophy courses with Paneth and read Feuerbach...One of the courses...deals with existence of God, and Professor Brentano, who lectures on it, is a marvellous person. Scientist and philosopher though he is, he deems it necessary to support his expositions with this airy existence of a divinity...*

A few months later in March 1875 he tells of an ongoing debate with Brentano and how far he is drawn to model himself on him:

*I shall personally tell you more about this peculiar, and in many respects, ideal man, a teleologist, a Darwinian and altogether a darned clever fellow, a genius in fact. For the moment I will say*
only this: under Brentano’s influence I have decided to take my PhD in philosophy and zoology.14

Brentano may have influenced Freud’s later excursions into metapsychology but for the moment, the plan to study philosophy was to be pushed into the background as Freud discovered an even more impressive model in Ernest Brucke and launched himself into a career as a laboratory based neurologist. But more than twenty years later, as he was uncovering the ‘great clinical secret’ of childhood sexual seduction and aggression that were to be the foundation of psychoanalysis, the old longing awakened by Brentano was still present. On 1 January 1896 he wrote to Fliess:

I see that you are using the circuitous route of medicine to attain your first ideal, the physiological understanding of man, while I secretly nurse the hope of arriving by the same route at my own original objective, philosophy. For that was my original ambition, before I knew what I was intended to do in the world.15

The Wolfman – a crucial test case

While Kraepelin could criticise psychoanalysis with all the authority of the man who had put psychiatry on a scientific footing, Freud found his own opportunity to question the therapeutic effectiveness of his approach in the case of an individual patient who had turned to him in desperation after years of unsuccessful psychiatric treatment.

The contrast between the two approaches in both diagnosis and treatment is vividly illustrated by this man who became the subject of one of Freud’s best known case histories – the Wolfman. Freud introduces him by saying that as a result of his illness:

...the patient spent a long time in German sanitoria, and was at that period classified in the most authoritative quarters16 as a case of

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16 A footnote in the text based on Ernest Jones’ biography of Freud states that among the psychiatrists consulted by the patient was Kraepelin.
'manic-depressive insanity’... But I was never able, during an observation which lasted several years, to detect any changes of mood which were disproportionate to the manifest psychological situation either in their intensity or in the circumstances of their appearance. I have formed the opinion that this case like many others which clinical psychiatry has labeled with the most multifarious and shifting diagnoses\(^\text{17}\), is to be regarded as a condition following on an obsessional neurosis, which had come to an end spontaneously but has left a defect behind it after the recovery.\(^\text{18}\)

So instead of treating this man as a manic-depressive, suffering from an illness that would simply have to run its course, Freud engaged him in a lengthy analysis which reached a successful resolution with the uncovering of the long repressed memory of the primal scene which had traumatised him, dominated his life from his early years and resulted in a crippling psychiatric history and many years in psychiatric asylums.

This experience of Freud is one that is familiar to every analyst. Hasty diagnoses of the type described by Daniel Burston all too often result in the attachment of a lifelong label of psychosis to a patient, whereas the cautious approach recommended by Freud may offer the possibility of a very different outcome. As he puts it:

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I \text{ 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.}\(^\text{19}\)
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This is not to say that his procedure leads to certain diagnosis: ‘...it is only one precaution the more’\(^\text{20}\)

Having outlined the positions of the two men whose work continues to dominate thinking on mental illness to this day I would like to go on to discuss two practical issues that concern the training of therapists and the

\[\text{17}\text{ My emphasis}\]
\[\text{18}\text{ S. Freud. A Case of Infantile Neurosis. S.E. XVII. p. 8.}\]
\[\text{19}\text{ S. Freud. On Beginning the Treatment. S.E. X11. p.124.}\]
\[\text{20}\text{ Ibid., p.125}\]
treatment of patients. The first of these is the use of psychological testing in assessment, and the second relates to the practice of the case presentation.

**Psychological testing – the patient as object of assessment**

Daniel Burston’s concluding advice, in attempting to remedy the confusion in which the diagnosis and treatment of bipolar patients has become mired, includes the recommendation that:

... *every patient who is suspected of having this grievous disorder is given a searching, sympathetic and above all thorough diagnostic assessment ...*  

This is a position that for many years I would have embraced, and in fact participated in as a clinical psychologist in a multidisciplinary team. But I no longer agree with this practical, sensible and apparently humane way of dealing with seriously ill patients and to explain this change of mind I will have to give a little personal history.

My first introduction to psychology was by two great psychological diagnosticians, Anne Anastasi of Fordham University, New York and Theodora Alcock of London’s Tavistock Clinic.

Anne Anastasi was the author of a number of standard texts on psychological testing, psychological statistics and differential psychology and was a ruthless critic of most of the paper and pencil tests used by psychologists to this very day. On the other hand she did approve of a number of cognitive and affective tests on the basis of their statistical reliability and validity and favoured their use in the assessment of individuals and groups. She was incidentally highly sceptical of psychoanalysis and its methods.

Theodora Alcock was a very different proposition. She was a child analyst who had been on familiar terms with many of the greats of the English analytic tradition – Melanie Klein, John Bowlby, Ernest Glover – and had worked with Anna Freud in the Hampstead Clinic during WW II.

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21 D. Burston, *op. cit.* p. 11
She was one of the founders of the Tavistock Clinic and participated in the setting up of the WHO, but her passion was the Rorschach and her *The Rorschach in Practice* was for many years a standard text on the test. Her own ability to use the Rorschach for diagnostic purposes was nothing short of astonishing and I recall her analysing an assessment I had carried out and predicting a brain disorder which only became obvious to the client’s doctors several years later. Like Anne Anastasi she seemed to me a model of what a clinical psychologist should strive to become.

But this brings us back unexpectedly to the Freud/Kraepelin debate. Anastasi’s statistical approach was unashamedly scientific and objectifying and led right back to Wundt’s laboratory. But Theodora Alcock also, despite her psychoanalytic formation, was using a diagnostic method that had been specifically rejected by Freud.

In my own case the goal was to master these subtle and powerful diagnostic instruments, and it never entered my head that I should have any scruples about seeing those on whom I used them – at the service of child guidance clinics, career guidance services and eventually here at the psychiatric department of St Vincent’s University Hospital as psychological objects. How, I thought could psychiatrists do even supportive psychotherapy without an accurate reading of the cognitive abilities and personality structure of their patients as elucidated by rigorously valid and reliable psychological testing?

**Speaking subject versus psychological object**

All of this was a very bad preparation for the Lacanian psychoanalysis I was to encounter in Paris. In the US of the 1960’s psychoanalysis seemed to be a mysterious unscientific practice, reserved to fully qualified psychiatrists with some unfathomable qualities that allowed them to be admitted to institutes that had no relationship to the university and who were often well into their forties before they could practice. Many of these analysts had no hesitation in using all the resources of psychological assessment to get to know their patients at the beginning of the treatment and to get a measure of their progress as it advanced.

This, as we have seen, runs counter to Freud’s recommendation. And in Lacan’s return to Freud, the rationale behind the objection to the use of psychological testing was given a renewed emphasis. Psychoanalysis is concerned with the subjectivity of the patient and the particular subjective
crisis that has given rise to his illness. Psychological tests are not designed to assess subjectivity, but rather the individual’s capacity to relate and accommodate to objective social situations. Hence, psychological testing received its greatest boost in World Wars I and II, when the different abilities of millions of men had to be measured in terms of the specific perceptual, intellectual or manual skills required to handle complex military machinery, or the emotional qualities needed to relate to others in the strange environment of a submarine or an airplane. Testing has proved its worth in the accurate assessment of such skills and qualities.

But for Lacan, as for Freud, access to the subjectivity of the patient can only be through his speech. And Lacan sharpened this focus by his formulation: ‘the unconscious is structured like a language’. This allowed him to describe the pathways to the unconscious discovered by Freud – dreams, slips of the tongue, jokes and repressed memories – as ‘formations of the unconscious’ and to see symptoms also as fundamentally linguistic phenomena. Once you go down the path of treating your patient as a psychological object to be assessed, then you can give up any attempt at psychoanalysis. You are no longer dealing with a subject, a speaking subject, you are dealing with a psychological object that you are going to treat.

In my own practice of psychological testing, little place was given to the spontaneous utterances of the patient except as a way of establishing contact in order for the real work of the scientific assessment to proceed. For me, the most powerful corrective to this procedure was precisely the experience of Lacan’s way of conducting a case presentation.

Lacan’s case re-presentation

For over twenty years, at his weekly case presentation in St-Anne’s psychiatric hospital in Paris, Lacan demonstrated the fruitful interaction between what are often considered – especially in our own day - to be two irreconcilable approaches to the understanding and treatment of mental illness. He used the hallowed method of the psychiatric case-presentation

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which Freud apparently never used – to demonstrate the most fundamental axioms of psychoanalysis. What is more, the majority of those presented were psychotic – precisely the kind of patient that Kraepelin, and many present-day psychiatrists, think are likely to be damaged by psychoanalysis.

In fact, for Lacan, nothing better displays the fruit of his forty-plus years of teaching and practice than the so-often neglected words of the inmates of a large public psychiatric hospital:

_of course, for me, for my discourse, everything starts from there. Because... I heard, I heard things that were quite decisive, anyway, that were so for me... I mean that the people who are here, confined within the walls, are quite capable of making themselves understood, provided one has the proper ears for it.... This is what they call my case presentations consist in...this presentation consists in listening to them, which obviously is not something that happens to them at every street corner._

Thus, listening to the patient is the core of Lacan’s case presentation and what, he argued, should be the fundamental task, not only of the psychoanalyst, but of the classically trained psychiatrist insofar as he comes to realise that the Kraepelinian thesis that founds scientific psychiatry must be confronted with Freudian antithesis of the speaking subject. To ignore the reality of the subjectivity of the patient is simply to ignore clinical reality and to engage in the sterile pretence that one is dealing simply with manifestations of brain activity rather than a self-conscious articulate human being.

But there is the further twist to the Lacanian presentation which makes it specifically psychoanalytic. This has perhaps been best described by Christian Fierens:

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Far from being a simple presentation of a sick person, which would be limited to just the case, the work of analysis always presupposes a double presentation and therefore a re-presentation. The individual only enters analysis ... in so far as he goes beyond his simple presentation and allows himself to be presented a second time by his slips, blunders, symptoms and dreams: by his unconscious. The subject in analysis ... is presented and presented again: he is re-presented...In other words, analysis from the outset goes beyond the case presentation and goes on to the representation of the subject by the signifier. The object of study of psychoanalysis thus proves itself to be this strange twice-presented subject...

It has taken me many years to realise that the typical psychiatric case presentation as it has evolved in St. Vincent’s University Hospital, for example, is, probably unwittingly, a product of neo-Kraepelian and therefore ideologically anti-psychoanalytic thinking. It focusses on the illness rather than the patient in a way that is typical of Kraepelin’s approach. The presenter thus as such treats the patient’s depression, for example, as a particular manifestation of the general concept of depressive illness. This in accord with the Aristotelian-style syllogism: “Depression is characterised by certain signs; this patient displays those signs; therefore this patient is depressed.” And the illness is subsequently treated in accordance with the best scientific methods that have been found to deal with conditions of this type.

But in the midst of such scientific objectifications what becomes of the speaking subject?

**Conclusion**

In a short, powerfully argued article Ivor Brown, Professor Emeritus of Psychiatry at UCD has recently made a number of points confirming from his own vast experience the validity of a synthesis between classical psychiatry and the talking cure:

In dealing with psychiatric illness there is no treatment you can apply to a person that will bring about a real change in them. The person has to undertake the work himself and this involves pain and suffering...The issue here is not the giving of a drug; many of the psychoactive drugs can be the only way of making initial contact with a person who is psychotic, anxious or depressed so that therapy can begin. The question is whether they are given as a treatment, or as an aid to working in a relationship with a person. It is not the drug – it is the message that accompanies it that is really damaging.26

These remarks, together with a growing number of criticisms of current psychiatric practice in Ireland and the USA, demonstrate the damaging effects of the naive neo-Kraepelinianism that has dominated psychiatric formation in recent years. Confronted with the enormous financial and political power of the pharmaceutical industry, psychoanalysis may increasingly be viewed as an outdated cottage industry. But the large number of mental health professionals who attended and participated in this conference today, focussed on the dialogue between psychiatry and psychoanalysis in the treatment challenges of the increasingly diagnosed bipolar affective disorder, may indicate that the need for some form of synthesis is being increasingly recognised.

Hopefully this initiative of Noel Walsh and Patricia McCarthy will mark a further step in the cooperation of psychiatrists with psychologists, social workers and psychoanalysts in finding ways of helping those patients presenting with this grievous affliction ‘to recover their emotional and interpersonal equilibrium without the use of unnecessary neuro-toxins.’ 27

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27 D. Burston, op.cit. p. 11
Psychoanalysis, Psychiatry and Bipolar Disorder in the Twenty First Century

Daniel Burston

During the last quarter of the twentieth century neo-Kraepelinian psychiatry joined forces with non-psychiatric critics to repudiate and ridicule Freud and his followers. This paper addresses some of the causes and consequences of the decline of psychoanalysis within mainstream psychiatry, and argues that many of the reproaches once leveled at Freud by his late twentieth century critics could now be directed with equal or even greater justice to neo-Kraepelinian psychiatry. This is especially true with reference to bipolar disorder, where contemporary psychiatry would be wise to heed its own motto: ‘Back to Kraepelin’.

Keywords: Bipolar disorder; DSM; Freud wars; Kraepelin; polypharmacy

In March of 1987, I was an Oscar Diethelm Fellow at the History of Psychiatry Section at The Payne Whitney Psychiatric Clinic in New York City. My supervisor was Eric (“Ted”) Carlson, a specialist in the history of phrenology, hypnotism, American psychoanalysis and multiple personality disorder. After one of our seminars, I asked Ted what he thought the twenty-first century held in store for psychoanalysis. To my astonishment, he said it would probably go the way of phrenology. In addition to being surprised, I was a little offended by his remark. Weren’t phrenologists charlatans, by and large? Now it was Ted’s turn to be offended. He shot back that until the mid nineteenth century or so, most phrenologists were perfectly respectable physicians. No, he said, he was merely suggesting that with the passage of time, clinicians would differentiate what was valid in psychoanalysis and then discard the remainder, and that those elements of enduring value would be absorbed into a new and genuinely scientific discipline, much as phrenology gave way to neurology.

Even when Ted explained to me what he meant, I found it difficult to credit this prediction. Psychoanalysis was falling on hard times, but I felt sure that in one form or another, it would survive. But looking back a quarter century later, I almost can’t believe my own naïveté. After all, a decade previously, Gerald Klerman, at Yale, had published a neo-Kraepelinian manifesto, calling for the repudiation of psychoanalytic
modes of thought and practice, and placing extravagant hopes in the powers of brain imaging and psychotropic medication to unravel the baffling mysteries of mental disorder. Moreover, we were in the thick of ‘the Freud wars’, in which Freud was subjected to scathing attacks from Frank Sulloway, Elizabeth Thornton, Jeffrey Masson, Adolf Grünbaum, Frederick Crewes, Mikkel Borch-Jacobsen, and Peter Swales among others. In effect, they were arguing that psychoanalysis had about as much scientific merit as phrenology did! And remember, the critics of that era were forceful and articulate. Their books and articles sold well, and rejoinders from the psychoanalytic community were often feeble, unfocused, or simply unintelligible to non-psychoanalysts. That being so, it is interesting to note the majority of ‘Freud bashers’, as they were called, were not psychiatrists, psychoanalysts or even psychotherapists, but an unlikely assortment of Sanskrit scholars, English professors, linguists, historians and philosophers of science – some, like Borch-Jacobsen, with strong deconstructionist leanings. While there was no conscious collusion among them, as far as I am aware, the ‘Freud bashers’ were natural allies of Klerman and Company, who seemed to relish every fresh assault from the Freud-bashers as a personal triumph, and as proof of the justness of their cause. So all things considered, 1987 was not a good year for psychoanalysis. But despite the darkening horizon, I could still imagine that psychoanalysis had a fighting chance. Those hopes dimmed appreciably with the introduction of fluoxetine, or Prozac, one year later. By 2005, some seventeen years after the FDA approved Prozac, one in ten American citizens had a prescription for anti-depressant medication, and by 2008, a hundred and sixty four million prescriptions were written for anti-depressants, and sales for anti-depressants alone totalled 9.6 billion.

dollars.\textsuperscript{9} Of course, quantitative data, as frightening as they are, only tell us so much, and it is impossible to spell out all the clinical and cultural transformations wrought by the Prozac revolution in detail. Suffice it to say that before Prozac hit the scene, the majority of clinicians, when confronted by disorders of mild to moderate severity, seldom thought of medicating their patients, especially if they were children. Medications were generally used for severe disorders, and then only sparingly, and one at a time, until the right medicine, and the right dosage was found. With milder disorders, the question of whether to medicate or not only arose in relatively rare situations when psychosocial interventions were out of the question or simply inadequate on their own. That is no longer the case. Now, for most American psychiatrists, the question that immediately springs to mind when they initially encounter a patient is not ‘To medicate or not to medicate?’ but ‘Which medication is most appropriate?’ And this tends to be true regardless of the age of the patient, the severity of the disorder, and increasingly, of social class as well.

Moreover, as the Prozac revolution spread, psychiatrists construed inner and interpersonal conflicts increasingly as the result of neurological problems or deficits, and paid less and less attention to the patient’s history or present-day circumstances. As a result, the nature and length of diagnostic assessments were drastically curtailed. Lauren Slater,\textsuperscript{10} an American psychologist who attempted to replicate David Rosenhan’s famous pseudo-patient study at nine different psychiatric facilities in the USA, was seen for an average of twelve and half minutes before receiving a diagnosis, usually of psychosis. Her experience is fairly typical. Even in cases of severe mental disorder, the idea of doing an in depth medical and developmental history of the patient is \textit{passé}, or often delegated to psychologists or social workers whose findings are often ignored or overlooked by the psychiatrist.

In addition to these deep and widespread changes to the practice of clinical psychiatry, the Prozac revolution had a profound impact on the treatment of bipolar disorder. Prior to the introduction of Prozac, monotherapy with Lithium had yielded mixed results, providing tangible benefits to between 40-60\% of patients, depending on which study you refer to. But in the lateeighties and early nineties, polypharmacy became


exceedingly popular, so Prozac and other Selective Serotonin Reuptake Inhibitors SSRIs were added to the pharmacological ‘cocktails’ that most bipolar patients were now taking. As Robert Whitaker\textsuperscript{11} points out in \textit{Anatomy of An Epidemic}, with the passage of time, the psychiatric ‘cocktails’ administered to bipolar and schizophrenic patients in the USA became more and more similar, to the point where, in many cases, they are almost indistinguishable – a fact noted one year previously by Richard Bentall, a practitioner of Cognitive Behaviour Therapy (CBT), and the author of \textit{Doctoring the Mind: Why Psychiatric Treatments Fail}.\textsuperscript{12}

Both Bentall and Whitaker have useful and illuminating things to say about bipolar disorder. Given the time at my disposal, I cannot repeat them here. However, drawing on papers published by many reputable psychiatrists, including David Kupfer from the Western Psychiatric Institute and Clinic in Pittsburgh, Robert Whitaker demonstrates that the new chemical cocktails have not lived up to their promise, or even proven appreciably better (in the long term) than monotherapy with Lithium. On the contrary, more often than not, the newer approaches to the pharmacological treatment of Lithium trigger a dreary descent into chronicity, robbing many patients of the chance at a full recovery. Moreover, the newer cocktails provoke more frightening side effects than Lithium alone produced. These include severe impairments to patients’ overall physical health, measurable cognitive impairments, diminished social and vocational competence and pronounced tendencies to withdrawal.

On reflection then, the new approach to treating bi-polar disorder seems less effective and \textit{more} expensive, if you consider the collateral damage to the patient’s health (and the tax payer’s wallet.) If Whitaker is right, the main beneficiaries in the new diagnostic and treatment regime in the USA are not patients, but pharmaceutical companies and their shareholders.

These developments must not be viewed in isolation from larger trends in American psychiatry. For example, as many of you no doubt remember, in 2008 there were numerous headlines about Senator Charles Grassley, the ranking Republican on the Senate Finance committee, who convened a series of Senate hearings into the finances of Dr. Joseph Biederman, the head of Pediatric Psychopharmacology at Harvard, Dr. Alan Schatzberg,\textsuperscript{11,12}

Head of Stanford University’s Psychiatry Department and President elect of the American Psychiatric Association, and Dr. Charles Nemeroff, the Chair of Psychiatry at Emory University. All three were principal investigators for research on the impact of pharmacological agents. All three collected enormous fees for speaking engagements sponsored by drug corporations, and Nemeroff, in particular, was guilty of not disclosing substantial personal gifts from pharmaceutical companies to the tune of 500,000 dollars.  

However, of these three psychiatric researchers, I find the case of Alan Schatzberg the most disturbing. Schatzberg, please recall, was the President of the American Psychiatric Association, and Grassley discovered that Schatzberg controlled more than $6 million worth of stock in Corcept Therapeutics, a company he co-founded. At the same time, Schatzberg was the principal investigator on an NIMH grant that included research on a drug Corcept Therapeutics was testing as a treatment for psychotic depression, and a co-author of three papers on the subject. Stanford University, Schatzberg’s employer, professed to see nothing wrong with this state of affairs. 

Now, as a psychologist, I can’t help wondering whether Schatzberg and his associates at Stanford were engaging in conscious hypocrisy at this point, or whether they really believed their own rationalisations. And for the life of me, even now, I can’t decide which scenario is more bizarre and disturbing. Either way, this discovery marks an historic low point for the psychiatric profession in the USA, and suggests that instead of being an anomaly, or a source of astonishment and outrage, conflict of interest has merely become the ‘new normal’. This impression is strongly reinforced by Marcia Angell, who reports that two-thirds of American psychiatric research centres hold stock in the companies whose drugs they are supposed to test, and that two thirds of department chairs receive departmental or personal income from drug corporations. 

Meanwhile, Allen Frances, the principal editor of the Diagnostic and Statistical Manual of Mental Disorders DSM-IV, has become increasingly forthright in his criticism of the soon-to-be published DSM-V.  

Frances claims that the new DSM was composed in an atmosphere of unparalleled

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secrecy, with no regard for conflict of interest issues or normal scientific discourse and debate. According to Frances, the DSM-V pathologises many normal behaviours that entail suffering – like grief or shyness - by giving looser, more inclusive definitions of existing psychiatric disorders, and by inventing new (and specious) categories of psychiatric disorder to account for them. The result, he claims, is that tens of millions of people will be inappropriately diagnosed and medicated, and therefore, victims of iatrogenic illnesses or one sort and another.

The irony is that already in the DSM-IV, which he edited, there was almost no item or aspect of human experience or behaviour brought on by intense psychological distress that could not be misinterpreted as the result of a specifically medical or neurological problem. Indeed, since the Prozac revolution, most psychiatrists (and many psychologists) must be repeatedly reminded that being rocked by grief, livid with rage, paralyzed with anxiety, or even confused, disoriented and prone to mood swings are perfectly intelligible responses for people in extremis. To label these emotional states as symptoms of disease without first looking deeply into their unconscious determinants and/or their traumatic origins entails a profound denigration of the human person. And if the real roots of suffering are ignored, or addressed with inappropriate remedies, suffering increases, rather than diminishes in severity. Adding new categories to our extant catalogue of mental disorder, or expanding old ones to become more vague and inclusive, simply widens the scope of this problem.16

As we all know, of course, Bipolar Disorder antedates the giddy and headlong inflation of the DSM by a century or so. It was first described by Emil Kraepelin. He characterised Manic-Depression – as it was then called – by long bouts of debilitating depression, punctuated by bursts of frenzied activity, accompanied by sleeplessness, grandiosity, recklessness, incoherence and giddy euphoria, which frequently escalates from odd or destructive behaviour into frank psychosis. Depression punctuated by less florid symptoms of mania was termed hypomania, and mania that was not followed by obvious depressive symptoms was simply called mania. The average age of onset for bipolar disorder was between 15 – 44 years. It affected both sexes equally, and afflicted between 0.5 and 1.5 % of the general population across the globe.

Up until 1985 or so, the dogged consistency of these findings across time and place suggested strongly that bipolar disorder is strongly influenced by genetics, rather than culture or environment. This state of affairs started to change as the authors of the DSM expanded their classification to include four discrete versions of bipolar disorder, each with its own unique profile. Now vast numbers of people have become candidates for some version of this psychiatric diagnosis, and the diagnostic process in which they are labeled bipolar is usually a perfunctory affair, lacking depth and nuance.

These reflections provide new insight into the crisis for psychoanalysis in last quarter of the twentieth century, and the problems that bedevil psychiatry in the first quarter of the twenty-first. Remember that as the year 2000 approached, Freud was reproached with increasing frequency and vehemence for altering or suppressing vital information in his case histories. The charge, in brief, was that Freud had taken liberties, altering the facts to suit his theories, and that his followers accepted his ‘doctored’ version of events as the unvarnished truth, basing their theory and practice on some contrived and tendentious accounts of patients and their treatments. Moreover, critics such as Masson, Sulloway17 and McMillan18 bemoaned the fact that these accounts were used as marketing tools, to ‘sell’ the unsuspecting public on a method that was ethically unsound or without a sound epistemic foundation.

Let’s not pretend that these charges have no merit, or that there were no instances where Freud’s critics really misunderstood his background, ideas or intentions, and overestimated the extent of his bias and dishonesty. Both these statements are true to varying degrees, depending on which of the ‘Freud bashers’ we are talking about. But while this argument is doubtless worth having sometime, at the moment it is quite beside the point. Why? Because no matter how often or egregiously Freud fudged his data, his dishonesty pales in comparison with the routine distortion and suppression of data that occurs in most of the large scale studies of many pharmacological remedies currently in use.19,20,21

21 R. Whitaker, op.cit., 2010
Please think about this for a moment. Ask yourself, how many case histories did actually Freud write? Let’s dispense with the customary precaution of distinguishing between his pre-psychoanalytic and psychoanalytic case histories, or between his “real” case histories and his speculative excursions into the lives of Moses, Leonardo and Woodrow Wilson, etc. Those distinctions may matter a great deal to Freud scholars, but they have no relevance here. For the sake of argument, let’s consider ‘the whole enchilada’. However big that number is, in the final analysis, the total number of cases Freud altered or embellished in the interests of ‘selling’ us on his point of view is quite minuscule in comparison with the number of psychiatric drug trials conducted by the major pharmaceutical companies in any given year.

‘Alright’, says a skeptic, ‘But to make a fair comparison, you’d really have to include all the slanted case histories authored by all psychoanalysts to date before comparing them to the aggregate number of drug trials’. Fair enough - though obviously, that number will be much more elusive, and is well beyond my capacity to provide. But even assuming that you knew the precise number of slanted case histories published by analysts over the years, a comparison of this kind would only be genuinely fair if it tallied up the total number of psychiatric drug trials conducted since the Prozac craze, factoring in the total number of 1) experimental subjects and 2) psychiatric researchers involved (including psychologists and social workers) whose names appear on the published reports.

Crunching these numbers would be an extremely daunting challenge, because The National Institutes of Health reports that some 58,788 drug trials have been conducted outside the USA alone since 2000. And as recent reports disclose, there are literally thousands of (smaller scale) drug trials conducted in poor and remote countries that go completely unreported and undocumented, owing to bribes paid to corrupt officials and bereaved family members. But even in the absence of careful quantitative comparisons, the overall pattern is already clear. When it comes to lapses in ethical conduct, due to secrecy, deception and self-deception, and failing to avert potential harm to patients, Klerman’s followers - including major researchers like Biedermann, Nemeroff, Schatzberg and Kupfer - have nothing to gloat about. Indeed, they have much to fear from careful quantitative comparisons with the psychoanalytic psychiatry of yesteryear, if these were ever actually undertaken. Please don’t mistake my tone. I am not trying to get psychoanalysis off the hook for any of the misdeeds that came to light during the Freud wars. That is not my purpose. I am merely saying that
when you consider the millions of people now taking psychiatric meds, and try and estimate the potential harm done by misdiagnosis and excessive or reckless medication in the USA alone, the difference in scale is just mind boggling. And bipolar, or allegedly bipolar patients, are no exception.22

My advice? Our conference is predicated on the assumption that psychiatry and psychoanalysis have much to offer each other, as well as to bipolar patients. That may in fact be so, but I suspect that in the end, genuine collaboration between them may depend on psychiatrists taking their motto ‘back to Kraepelin’ quite literally, at least with respect to bipolar disorder. If we stick or return to Kraepelin’s original (and comparatively narrow) description and definition of the disorder, and discard the kind of indiscriminate disease mongering that the DSM has indulged in, we’d do much less harm than we do presently. Moreover, if psychiatrists joined with psychoanalysts and psychologists to ensure that each and every patient who is suspected of having this grievous disorder is given a searching, sympathetic and above all thorough diagnostic assessment - in which the person’s family and developmental history, and the possible impact of trauma, loss and unresolved inner conflicts are taken squarely into account - we will find ways of helping them to recover their emotional and interpersonal equilibrium without the use of unnecessary neuro-toxins, which don’t begin to address these issues in a satisfactory way. Even if bipolar disorder is effectively ruled out, as it would be increasingly, treatments to help these distressed and distressing people will take time and patience to work, no doubt. But what choice do we have, really? The quick chemical fix just isn’t what it was cracked up to be, now is it?

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22 Ibid.
ROUND-TABLE DISCUSSION

CHAIR

Professor Fiona McNicholas, UCD Professor of Child and Adolescent Psychiatry, Child and Adolescent Psychiatrist, Lucena Clinic, Orwell Road, Dublin

DISCUSSANTS

Kim Spendlove, Psychoanalytic Psychotherapist, North Clondalkin Probation Service, Dublin

Dr John Sheehan, Consultant in Adult Psychiatry, Mater Misericordiae University Hospital, Dublin

Elin Payne, Psychoanalytic Psychotherapist, Dublin

Dr Mary Cosgrave, Consultant in Old Age Psychiatry, North Dublin Mental Health Service

Dr Barry O’Donnell, Psychoanalyst, Head of Dept of Psychotherapy, DBS, Dublin

Prof Jim Lucey, Consultant Psychiatrist, Medical Director, St Patrick’s University Hospital, Dublin

Dr James O’Connor, Psychoanalyst, Dublin

Máire O’Connor, Psychoanalytic Psychotherapist, Solicitor, Dublin

Dr Conall Larkin, Consultant Psychiatrist, former Clinical Director, St John of God Hospital, Stillorgan, Dublin

Fiona McNicholas: Thank you all. It’s been a very stimulating morning and afternoon. When Patricia McCarthy asked me to chair such a large panel initially I thought she wanted me here on account of my conflict resolution expertise at dealing with ‘the fight or the split’, but as we’ve been reminded there hasn’t been any fight. In fact in a way I think that’s due to Patricia’s success at both planning the sessions where there has...
been a psychiatrist and a psychoanalyst in each of the slots and where the topic has been given very broad consideration. So sadly, those that were looking for the fisticuffs are going to go home disappointed.

The format of this final session is a round-table discussion. There are nine individual speakers here and I’m going to ask if you all wouldn’t mind stating your name and taking about two or three minutes to introduce where you work, whether you are in psychiatry, working as a psychoanalyst or both, and how your work might link with bipolar disorder presentation, that has been the link of today. We’ll just allow each the opportunity to do that.

After that, I thought I might ask each individual on a second round to give a reflection from the day and highlight an area or idea that was stimulating or controversial or insightful and maybe to suggest ideas for the future. If we do have time after that there may be an opportunity for the audience either to ask questions of the panel or indeed to give their own reflection on the day. So without further ado, let us proceed. I will do time management, if somebody is getting stuck beyond the three minutes introduction phase, I’ll alert them gently! Okay, would you mind awfully kicking off at this end, is that okay? Thank you.

INTRODUCTIONS

**Kim Spendlove:** My name is Kim Spendlove, I work with the Clondalkin Probation Team out in Dublin 22, so my background is in psychology and criminology. I came by psychoanalysis via the MA in Psychoanalytic Psychotherapy in DBS. I work with violent offenders, who are referred to me by their probation officers. These include people that have either come out of prison or who may be referred to me pre-trial. So some of them would have very, serious charges, including murder and manslaughter and I’d see them on a weekly basis.

**John Sheehan:** My name is John Sheehan. I’m a psychiatrist at both the Mater and Rotunda Hospitals in Dublin. My background is as a medical doctor, qualifying in UCD in 1980. I worked in branches of medicine for six years and then specialised in psychiatry. I did the Masters here in St. Vincent’s in Psychoanalytic Psychotherapy, graduating in 1990. So, I have an interest in psychoanalytic psychotherapy and psychotherapy in general going right back to the 1980’s. Currently, my work in the Mater includes things like medically unexplained symptoms - so psychotherapy and
psychoanalytic psychotherapy are very useful. The symptom’s meaning and the language used by the patient are very important. Similarly, in my work at the Rotunda, I treat women with postnatal depression and puerperal psychosis. Again, the psychotherapeutic aspect is very important in the overall care of the woman. In general, psychotherapy informs my work and greatly enhances the quality of care I can provide.

**Elin Payne:** Hi, I’m Elin Payne and I’m a psychoanalytic psychotherapist working in the National Maternity Hospital in Holles Street under the supervision of the perinatal psychiatrist. I see women who are having difficulties with issues of pregnancy and childbirth and motherhood. I’m a recent graduate of the DBS MA, where I was on placement with Dr Sheehan. As a psychoanalytic psychotherapist working within psychiatry, I feel privileged to be in a position which relies on the complementary relevance of these different perspectives, which I think has been a predominant theme today.

**Mary Cosgrave:** I’m Mary Cosgrave. I’m an old age psychiatrist by training. I’m also trained as a general psychiatrist and I completed the MSc in Psychoanalytic Psychotherapy here in St Vincent’s about ten years ago in the year 2000. My main interest is in psychiatric illness in later life, and in dementia in particular, but also in bipolar disorder in the elderly. In recent times I have a new post: I’m actually working as a Manager. I found this very interesting today in terms of resources and how one would look at services and development of services. So I found it interesting looking at the place of therapy from that managerial angle today.

**Barry O’Donnell:** My name is Barry O’Donnell. I’m Head of the Department of Psychotherapy in DBS where we have the MA in Psychoanalytic Psychotherapy amongst other things. I have a psychoanalytic private practice. In the past I would have spent a number of years in Trinity Court, in addiction services, working on the multidisciplinary team there with a psychiatrist Doctor John O’Connor. I also have a connection here at St Vincent’s and University College Dublin with the programs in the School of Psychotherapy having completed what was then the Diploma and subsequently the MSc in Psychoanalytic Psychotherapy some years back. I suppose one of the things that has been coming up today, and we’ll come back to it perhaps, is the question of how to educate or contribute to formation in this particular kind of work in an age when education is expected to happen on a mass scale. And Cormac
Gallagher mentioned a “cottage industry” earlier, and Mary [Darby] - you were asked for the source for this idea, as opposed to mass production, in the current processes of education and assessment.

**Jim Lucey:** My name is Jim Lucey and I’m a psychiatrist, and the Medical Director of Saint Patrick’s University Hospital and have been in that post since 2008. In my own personal background - in terms of psychotherapy highlights - I suppose there are a few when I reflect on them. One, I spent a year as a research fellow with the late Professor Anthony Clare working on various aspects, principally biological but also psychological, of obsessive compulsive disorder. And then I went on to spend three years working as a Welcome Fellow with Isaac Marks in the behaviour therapy unit at the Maudsley Hospital, London. This was - giving my age away - before cognitive behaviour therapy rose to fame and behavioural therapy was then in the ascendant. Since becoming Medical Director I’ve been lucky enough to work with a team that has tried to enhance psychotherapeutic activities at Saint Patrick’s which is the largest independent not-for-profit provider of mental health care in the country. Collectively we admit annually about 2600 people to our service, but we see roughly another 3000 new people per year. There’s a one in twenty chance of being admitted if you come to our community service, which is based at clinics we call Dean Clinics. The bulk of treatments are psychotherapeutic. In a range of clinics we’ve established over the last three years, four Dean clinics are in Leinster, one in Cork, another opening in Galway soon. The emphasis in these is in delivering psychotherapeutic and social remedies to the bulk of mental health issues and the most popular psychotherapeutic modality people seek is cognitive behavioural therapy.

**James O’Connor:** I am James O’Connor. I’m a psychoanalyst/psychotherapist with the Kilbarrack catchment, Area 8, HSE, in Dublin. There are two consultancies there, Kilbarrack East and West. I work with out-patients from both, at Saint Francis Day Hospital, Raheny. I came to that service initially in 1997 and trained there for about four years with a small cohort of patients. The second two years of that time included the psychoanalytic psychotherapy course here in St Vincent’s. My background hitherto was in academic psychology as well as psychology and business research, because I had a business background. Initially there were no psychological services apparent within the group when I came there, except a small mental handicap incidence in Saint Ita’s Hospital. This was my introduction to psychiatry then, to the omnipotence of the medical model of
mental illness / health - so it was necessary for me to find a niche. I found this when I saw the team were in some difficulty and I requested that I work with a particular client who was at the core of this confusion. I was fairly successful in this and psychiatry reciprocated by allowing a continuance with other patients. So almost from the outset, this confluence between me / psychoanalysis and psychiatry was set in train. Initially I didn’t have a psychoanalytic background - that came later. But with me as an individual, and later as psychoanalytic therapist, the confluence with psychiatry began to work reasonably well. Now we have a situation where we’ve got many different forms of therapy and a different kind of team group psychology / dynamic. The psychiatric service has accustomed itself to different inputs. Whereas initially, I would have seen different types of patient referrals, now it’s more streamed, ‘psychologised’ and / or “psychiatrised” as it were, with referrals coming from the psychiatric consultants or clinical psychologists in service assessment. Quite early on I began to use the Lacanian sessional format, to show psychiatry how efficacious this would be, from both economic as well as therapeutic perspectives, enabling twice as many patients to be treated with limited ‘hourage’. And once the patients get used to a different format you find it works very well. I have seen quite a lot of people on both a short and a long term bases over the past 14 or so years. And so psychiatry has got to know me quite well over time and correspondingly, has got to know the effects of psychoanalysis on psychiatric patients.

Máire O’Connor: My name is Máire O’Connor, we’re not related! I spent most of my career as a Solicitor in an area completely unrelated to what we’re talking about today, that is, the supposed big bad corporate and financial world. But I developed an interest in psychoanalysis over the years and just recently completed the Masters here in St Vincent’s. As part of that Masters I needed to be seeing clients. Through a contact at Saint James’s Hospital in the GUIDE Clinic there, I offered the services of psychotherapy on a voluntary basis for patients who had been diagnosed with HIV, for the duration of the Masters course. But then I agreed to continue it, still on a voluntary basis, seeing patients two half days a week. However, I’m not employed by the hospital. I suppose it’s somewhat different to what we might have been talking about during today about psychiatry and psychotherapy. This was actually an initiative in both directions, from me /and from the Consultants in the GUIDE clinic itself rather than anything within the Psychiatry Department in the hospital. It is interesting how it has been accommodated there as a separate service with total confidentiality and no reporting or anything like that between myself
and the social workers or the Consultants. That, for me, was an essential aspect of the therapy. So, somewhat unusual I suppose in the context but I think it was a very interesting initiative. It was something that the service really wanted to happen there. They didn’t have the funding for it but they just made it work.

**Conall Larkin:** I’m Conall Larkin and I’m a recently retired psychiatrist. I was medical director at Saint John of God Hospital from 1992 up to three years ago when I stepped down and I’ve been working as a consultant psychiatrist for the last three years. Most of my training took place here and at the University of Western Ontario in Canada in the 1970’s. There the teams were very differently resourced at that time. They were truly multidisciplinary. There was a very strong psychoanalytic influence, equally balanced by biological input and all members of the team were fully respected. They used brief psychodynamic psychotherapy, something quite unusual in Ireland at that time. When I returned to Ireland, I was fortunate to return to Saint Vincent’s University Hospital to work with Professor Noel Walsh and Dr Mary Darby. Around that time Cormac Gallagher had returned from Paris with his Lacanian ideas, Tom McGrath had come back from Austria where he had studied group psychoanalytic psychotherapy. I brought back some thoughts on self psychology based on the work of Heinz Kohut of the Chicago School. At the weekly seminars and discussion we occasionally had input from some of the Monkstown analysts. It was a very diverse and vibrant group and from it The School of Psychotherapy here at St. Vincent’s gradually evolved. Since that time I have been involved in undergraduate and postgraduate education and running supervision groups for Psychiatry Registrars. My interests gradually evolved into an interest in psychotic disorders, in particular, schizophrenia. In an attempt to understand psychotic illness it was my longstanding wish to try and integrate psychoanalytic and biological theories of schizophrenia and to try to develop a greater understanding of that condition. My own psychodynamic views have shifted over the years from a Freudian model to a developmental model. I have been influenced more by those who have contributed to the literature from the observational studies of children and the childhood prospective studies. I think that these have been the greatest influence on my thinking at this point in my career.

**Fiona McNicholas:** Thank you all very much. I’m interested now in having each of your perspectives about the different components of what we have heard today, and how it resonates with your work, whether that is in a clinical capacity, or in a managerial position. It
would be interesting to learn how you see psychoanalysis, and whether you share Dr McCarthy’s concern that it may not happen in our lifetime that psychoanalysis would become a much more standard part of typical psychiatry clinics. As a child psychiatrist - and, I have some child psychiatrist colleagues in the audience - we are lucky in that we have always valued psychotherapeutic treatment as part of our overall assessments of children.

REFLECTIONS

Kim Spendlove: Today was really informative. As I am a relative newcomer to psychoanalysis, I suppose for me the evidence of the effect of a psychoanalytic listening, is in how it works. Basically, the clients that I have are clients that are difficult to work with, and in some cases the Probation Service refer them to me, as they have found them problematic in the past. I believe that even the small things that happen, in the course of my analytic work, such as clients saying ‘thank you’ or ‘I’m looking forward to next week’ and the fact that they turn up every week whether court-mandated or not, is proof that, simply, the act of speaking is enough to make a difference in their behaviour in the outside world. This in itself is sufficient to convince me that the act of listening is working for them and that it assists them in working through a hostile and sometimes very difficult life. In addition, it is noteworthy to consider that at the end of their time with me they’re given a risk assessment test by their probation officer. And for the majority their risk of re-offending has been considerably reduced.

Fiona McNicholas: Thank you.

John Sheehan: I thoroughly enjoyed today too. What strikes me was how harmonious a lot of the talks have been.

Where I work, in the Mater, I’m fortunate to have students from DBS who join my own team for a block of ten or twenty weeks. The students are able to take on patients for time limited, brief individual therapies. This enhances the care that I can provide to people referred to my service. Furthermore, from the educational perspective, one of the things that I really value is having trainees in psychoanalysis as part of a multidisciplinary team. The Masters students bring a lot of knowledge and they bring a different perspective to the team. So, for the trainees in
psychiatry that are thus exposed to this, it really enhances and enriches their training, their development and their formation. I don’t see a conflict between psychiatry and psychotherapy or psychoanalysis - for me, they go absolutely hand in hand. The best outcomes are achieved in my service when the psychotherapy approach is combined with the medical approach.

In terms of service development, in an Irish context, I’d love to see a psychoanalyst as part and parcel of every multidisciplinary team. Not for one minute am I suggesting that everybody would be referred for psychoanalysis – in the same way that everybody does not need to see a social worker or clinical psychologist. But the fact that the resource would be there would enhance the service, enrich it. So, for me, psychiatry and psychotherapy working together in collaboration is the way it should be done. I think my own trainees would say that’s exactly how we do it.

So I certainly enjoyed today. Again, from the point of view of looking at bipolar disorder, I think that there is a place for both psychiatry and psychoanalysis. People with acute illness such as a manic episode who are overactive with flight of ideas require medication and a safe environment. Later, when stabilised, psychotherapy or psychoanalysis can help them when they are trying to make sense of their illness or understand their illness or give meaning to their illness. Combining psychotherapy with medical treatment results in better outcomes. So as I said, my main point is that psychiatry and psychoanalysis or psychotherapy should work together in a collaborative way.

**Elin Payne:** I agree completely with that. My work at Holles Street Maternity Hospital grew out of a placement that I had on the MA at DBS. When the placement was over I carried on there in a voluntary capacity. When I graduated, my supervisor asked if I’d like to continue and I agreed. He got clearance at Holles Street and they agreed - as long as I don’t get paid! I stayed and it’s been very interesting. As Patricia said, and as we’ve all noted, there’s a huge difference between psychiatry and psychoanalysis, but they can be really effective working together. The women that come and see me - they’re looking for answers. And hospital psychiatrists can often offer an answer to them or offer a treatment. But when I offer simply to listen, they can be taken aback at first, but then once they start talking they seem to keep talking. And they keep coming back. There’s a value in that which works with psychiatry but is different to psychiatry. I think what I hear is quite likely very different to what the psychiatrist hears but is equally valid.
Mary Cosgrave: I’ve also had placements of students from the DBS course and I must say I’ve had experiences very similar to John’s (Sheehan), a previous speaker. Indeed one of the students has also continued to work with us very successfully for the last four or five years. John Sheehan has described how psychoanalytic therapy works within his team and I think this is the way that psychoanalysis will find a place within the development of mental health services in Ireland. Mental health service development in this country is driven by the document, *A Vision for Change*. It is the only template for development and the only pieces of it that are currently prioritised are those that aren’t that expensive to implement, or those that the Mental Health Commission are mandating with the Mental Health Act and corresponding Rules and Codes of Practice. So as a manager, this is how we are expected to manage, conduct and develop services. We are to set up our teams in conjunction with *A Vision for Change* and they will be resource-driven on the basis that that is how we are operating. That is how resources will be allocated.

We have to show through collected statistics how many people we see and how long it takes to see them. We also have to show whom we discharge, as it is in our throughput that our success rate is measured.

This is the model we work in, and I think if you have to work with that model, the best route is to embrace it. Let us see what we can do within that model. In terms of the therapies I see a tremendous role for a psychoanalytic understanding of what’s going on and for the listening. But I have to see this role for the other types of therapies as well, such as CBT and maybe interpersonal therapy

Overall for me, the working of psychoanalysis/psychotherapy and psychiatry in patient care is a joint enterprise. We also need to look at managerial aspects of the treatments we provide.

Barry O’Donnell: I’m delighted to be hearing all these references to the MA in DBS and the MSc in St Vincent’s because I think that that’s very interesting. Earlier this morning, Brendan Kelly was talking about resources, and that they don’t have the posts that are recommended in *A Vision for Change*. But actually what can happen, and what has happened, as you have heard from those here with us, people have gone onto these teams and been part of [them], in their capacity as trainees and students on
Masters programs. So I think that’s something new that we can be creative about, rather than waiting for the Minister for Health, or whoever is in charge of the local health service budget, to give the go-ahead and that that initiative can allow for a psychoanalytic contribution. John [Sheehan] - you’ve often said to me that you get that contribution from the students and indeed those who then graduate and continue on seeing patients in the Mater. So I think that’s worth considering. And, you know, maybe developing further, rather than holding our breath and waiting for some big decision from Leinster House.

A couple of things from today. One of them is this phrase - it’s the title of a very useful book - The Normal and the Pathological by George Canguilhem, a French philosopher and medical doctor, as well a mentor for the philosopher Foucault. It gives us that phrase, - the normal and the pathological, - because that’s been coming up over the course of the day. When is something a condition that can only be dealt with in terms of some kind of pathology and nothing else? Because I think what’s been pointed out is that a lot of these things are normal. We’ve heard about hallucinations, temper tantrums and all of these things. This is what people experience, we all do, if we’re honest with ourselves. (Honesty is another question that came up earlier on.)

That’s what a diagnosis like bipolar, I think, has to take on. Are we looking for a diagnosis that has all the weight and kudos, of being objective and scientifically validated? Or do we have to say, well, hold on a minute, maybe we just have to listen to what the person has to say. We’ve heard a couple of examples of where people have been invited to speak and the practitioner has allowed themselves to listen and has tolerated the anxiety of being in the position of listening. That has really opened up something that, all of a sudden, whether it’s this diagnosis or that diagnosis - is really, by the way; because what’s happening is that this person is taking a step in their lives and beginning to speak. Some of the examples had a therapeutic effect and a therapeutic gain for them. So that’s the distinction, the normal and the pathological.

One of the texts that Brendan Kelly quoted from earlier on is Freud’s text ‘Mourning and Melancholia’; it is interesting because mourning is normal, where there has been a loss; and melancholia is considered more pathological. The other distinction - and Cormac [Gallagher] -you were speaking about this and had it in your title today - is between objectivity and subjectivity. And not trying to fit it all wonderfully together, but that,
there is an inevitable connection between pathology and subjectivity and whatever about the patient or client or person coming in the door, there is the subjectivity on the part of the practitioner. Because we heard that what happens when we open ourselves to listen to what could be quite mad talk? We will reach for, we need something to contain this [anxiety, the practitioner’s pathology]; we need some diagnosis or something like that and, I suppose, that’s a real question for us as practitioners: what each one of us think we need to do in order to be in that position and that maybe it’s not something that will come from the books. Again, going back to the point I made earlier, maybe it doesn’t come from getting the grades and that, going through college and getting your exams and all of these things that are necessary. Maybe it is more, to use that idea again of the cottage industry; that it’ll be much more in terms of working very closely with a supervisor, indeed with one’s own therapist, one’s own analyst in terms of clarifying, figuring out my own position in relation to this [practice]. So I suppose they are just some of the questions, certainly for me, that came out of the day and perhaps are for us all to consider.

Jim Lucey: Thanks Fiona. I just want to start by thanking Dr. McCarthy for inviting me and for having such a tremendous day. I think it has done a lot to achieve the synthesis that Dr. Gallagher talked about earlier. That synthesis must be our common aim. Those of us who are in health management or service providers have to say - well - where do we stand with this? And in a way that’s asking a question. Would you buy psychoanalysis? Would you pay for it? Will you hire people who do it? It is all very well, noble and admirable to work for nothing, but in reality working for nothing is neither a feature of psychoanalysts nor any other human behaviour that you want to sustain. So I think we have to say, would a service buy psychoanalysis, is one question. Our service spends 60 million Euro a year providing for a substantial proportion of our nations psychiatry and it does so, through insurance and donations and all the rest. It struggles without profit and it spends its money very carefully. The bulk is spent on psychotherapeutic staff and the bulk of its expansion has to be in psychotherapy. So the answer is undoubtedly and positively – yes - towards a psychotherapeutic service. For example we have recently appointed staff to our new adolescent service. A key appointment was a senior nurse who is dual-trained as a psychoanalyst (Colman Noctor). We saw skills in psychotherapy, but particularly in psychoanalysis, as being very valuable for our service. So, yes, we are prepared to buy psychoanalysis and psychotherapy.
I suppose I should try to synthesize what I felt from this wonderful day and what I particularly enjoyed - the mornings presentations. I would like to be brief but to hang my three ideas around three Irish names. The first would be the late Anthony Clare. The second is a sort of Irishman, although he’s probably more a Palestinian or an American, and that’s Senator Mitchell. And the third is Jonathan Swift, who was very definitely an Irish man, but an Irish man like Patrick Pearse whose father was an Englishman. These three names encapsulate three ideas that I think are relevant to this synthesis

Anthony Clare lived during the middle of the Freud wars. We heard about these this morning and he wrote a classic book. I think it’s worth mentioning, it is Psychiatry in Dissent. Psychiatry is unfortunately a fissiparous discipline, that’s a discipline that replicates by dividing itself. We have to guard against division upon division and strive to overcome conflict. Dissent is not productive for synthesis. The great strength of Clare’s work was its synthesis. It was written at a time when Ronnie Laing and Elliot Slater were metaphorically at each other’s throats, although they never met or spoke. Today’s meeting would not have happened and never did happen between Laing and Slater. Synthesis is the way forward and divisions and fights are actually about vanities as much as anything else.

The second name I want to mention, who isn’t really an Irishman but his place in Irish life is great, because it is about conflict resolution is Senator George Mitchell. What did Senator Mitchell do? He came here and he said (I parphrase) “let us have parity of esteem and parity of injury”. So there were Freud wars and now we have a war against the DSM and so now we’ll have the DSM wars. We really haven’t moved on from Psychiatry in Dissent. Both of these are vain-glorious pursuits that have nothing to do with our purpose. Let’s have parity of injury and say ‘Now settle it’ like Mitchell did around the table at meetings like this. Surely psychoanalysis has something to say about why we’re conflicted and why we have conflict with each other. The best psychoanalyst I have ever worked with was a Dr. Murphy who was a psychoanalyst on the NHS team in St. Bartholomew's where I worked as consultant for five years. She worked like me in the intensive care unit; in a unit which was eventful with criminality and psychosis, with tragedy and sometimes with horror. But her psychoanalysis was about the way we worked together in our service. And that was a hugely valuable psychoanalytic insight, which day and daily she helped us with. We saw it as a perfectly valid and useful use of the NHS buck that was paying for her work as a psychoanalyst in the
general service. So I would ask you to think of Mitchell and acknowledge parity of injury and move on.

The third name I would like to mention is Jonathan Swift. As you know, he was not a doctor. Forgive me for speaking up for him. I want to speak up for a man who set up this country’s first mental health service, and defined it as dedicated, independent and not-for-profit. If his achievement was only that, he would be just a footnote, romantically held by those who like arcane bits of history. But because he’s much more than that, it needs to be said what he did. He said, ‘He built a home for fools and mad and proved with one satiric touch, no nation needed this so much’. His followers derided him and decided that this was Swift’s joke; a joke on the Irish, no nation needed mental healthcare so much. But it was nothing of the kind. He believed that a nation or a society had responsibility to care for the mentally ill. Because he wanted to make it clear that mental health was the responsibility of the nation he, in effect, spoke for the justice of mental health care. So when we think of Dean Swift we need to think of an Irishman who stood up for mental health care as a human rights issue. It’s a human right that we are heard and Swift gave us that message, it’s an Irish message, one we can be very, very proud of.

Once again let me thank you for having this meeting. I have learned a lot.

James O’Connor: With regard to today and in reflecting on the last participant’s commentary, I was interested, because to me, that which was spoken of was essentially what I had already done and my life had changed as a result. I was searching for a new vocation, in my early 40s then, so where to get work or who would give experience to somebody, who didn’t come from a standard main-stream type background. I approached various places, people who might give some response and eventually, somebody said to me that I should ring St. Ita’s Psychiatric Hospital (SIH). I had never heard much about it except it seemed a horrific kind of a place. But suddenly when I phoned a very different kind of voice spoke to me and mentioned that I should get in touch with somebody who doesn’t exist anymore the late Dr. Mullaney. So I phoned him and he asked if I would send him a CV. I was awaiting a Ph.D adjudication at that time and so I did. I came to meet him subsequently at SIH and he introduced his colleague Dr.Cantrell. They asked me what I was interested in, if I had experience. I said this was why I had come to them. So they asked me to come to Saint Francis Day Hospital (SFDH) which I duly did and then to go out and sit in and watch the teams at work in SIH and then to attend the
Psychiatry consultants and registrar’s research and case presentations. Why did they do this? I have no idea, given the paramount nature of the medical model and where I stood in relation to it. All I can say is that it happened.

Okay, so here I was in the back of the group looking at the patients coming in, I would go to SFDH and just sit in with the team. I’d hear people being spoken about that I never saw, in a therapeutic sense. So it took probably eight or nine months of this activity before eventually I realised that a particular client was causing concern. I had never seen this individual except to read his review notes. But he had been readmitted to SIH so I knew I had to see him. I was quite shocked because I had thought he might be rather old but he turned out to be quite young and I didn’t understand this - chronic acuity and youth. But he had regressed significantly and was suicidal, so I thought here’s my chance. Maybe if I ask if can I work with him without any qualification other than academic ones, they won’t refuse me because I know they’re in trouble and appear desperate.

I did and they agreed and I went into the assessment unit, maybe three or four times a week. I sat with him on the floor and elsewhere. There was a subculture that existed there, where people would steal his cigarettes and do all sorts of different kinds of things to frustrate him. But we stayed talking and stayed working in that manner. I gave him some psychometric tests to complete, somewhat naively - Stress, Coping, Anxiety and other personality questionnaires. In eight weeks or so he was discharged and I began to work with him one to one at SFDH. Later, when the course began at St. Vincent’s Hospital I thought of a couch. Couches were unheard of where I was working. But they had floor mats - used for various purposes and I put some of these on top of each other so as to lift the patient off the floor a little bit and we began the analysis like that. Ultimately then through this course of analysis and following a couple of years of work he was discharged to Kilbarrack clinic. From then on, despite a prior ten-year history of various kinds of breakdowns and suicide attempts, he has never been readmitted as an in – or outpatient from that time.

This experience led to the gradual referral of a small cohort of patients for me to work with through the Masters course. I felt psychiatry began to have more confidence in psychoanalytic therapy and I thought perhaps that treatment of other forms of illness/symptoms might be possible here. So over time, let’s say with issues where chronicity prevailed, where cycles of inpatient / outpatient admissions/discharges needed breaking or something
different needed doing, or some element needed shifting, then psychoanalytic efficacy comes into play. Hospital admissions are costly and labour intensive. Outpatient psychotherapy is more cost effective. This is the way it developed over time. Psychiatry could see this therapy working economically as well as therapeutically and was proving adept at moving people out of the services completely – ending such cycles of circular chronicity of attend once for services. I rather concentrated on the particular - leaving others to evaluate its efficacy. Nothing that I have heard here today then other than that this gathering took place - has been strange to me because I have linked with psychiatry from the start. The confluence between psychiatry and psychoanalysis that was germinated initially, established itself and flourished and subsequently form an integral component of an expansive and disparate psychotherapy service within the Kilbarrack catchment.

I am very thankful to psychiatry for giving me a vocational focus in life and providing me with a practical basis for a living career. This - because of the experience I was given and my resultant reciprocation – provided an embryonic psychoanalytic service for public patients through community psychiatry. I remember those who at and through its establishment began to believe in what I did, particularly the development of an effective if diplomatic rapport with the then nursing officer. She requested only that I inform them of an imminent risk of suicide. Otherwise, psychoanalytic autonomy was sacrosanct. Psychiatry observed however, engagement in discourse, increased linguistic confidence, stability with reduced risk, medication reduction, diminution of symptoms, development of hope for a future among patients and an increased rate of discharges which were permanent rather than circular. They supervised the establishment and integration of a tried and trusted methodology of psychoanalytic treatment adding a new and non-threatening dimension to the existing service, while easing fears of both service users and providers by the results and effects of its rigorous scientific modus operandi. The provision of the couch followed easily and fluently as a natural consequence - perhaps with some initial respectful curiosity also, as patients adapted to it with facility. Our principal psychologist asked me some years ago how I got ‘that’ in here, but I have viewed it as a consequential symbol rather than an end in any sense. But ‘that’ exists in psychiatry, you know. And that’s the way that I look at it today. It’s familiar to me, it’s what I do. That’s how I look at it.
Máire O’Connor: Following on from what James has said, I don’t have a couch. I’ve been working within Saint James’s Hospital and in fact I use somebody’s office there when I’m there. But it’s still possible, as I’m sure you know, to work psychoanalytically, even without the couch and even when the setting isn’t, you might say, ideal. There were two particular points that had struck me about this during the conference today, which I found extremely interesting and important for the psychiatric/psychoanalytic dialogue. One was in relation to a question that I think you asked, Fiona, during Dr. Bailly’s presentation. I think, if I can paraphrase it, you were asking about adolescent bipolar disorder, and if these people had in some way got through that far from the - I think you said - the “utopia issues”. While I don’t have experience at all in relation to bipolar, something did strike me in relation to my experience with the clients I see who have been diagnosed with HIV, and how different and how particular their experience of that is. While I think it can be said that such a diagnosis is traumatic for each person, the experience of it is very different. And so I would say from a psychoanalytic point of view, that in fact the diagnosis of HIV, in a way, is a trigger: it’s a triggering event which brings up something, some trauma that may have been experienced at a much earlier stage. Now, it’s not easy in the context in which I operate to work around that because the focus is so much on the immediate problem, one might say. But at the same time, I want to highlight how different the experience of each person is. There are, unfortunately, an awful lot of people who are diagnosed with HIV. I am saying unfortunate in the sense of the diagnosis. But not all of them need to see a therapist or an analyst. However, there are those for whom this diagnosis is totally devastating, as a result of which they are completely undone. So, it was something that just struck me about what Dr. Bailly was saying in relation to that question that, perhaps, their somewhat fragile defences and coping mechanisms - with which they have lived what they have regarded as a reasonably successful and reasonably fulfilling life up to a certain point in adulthood - can be completely cut through by the diagnosis. Well, only for some of them, and I think that is something that is so important in psychoanalysis, the particularity of the subject. And, if I have another minute, I’d just like to mention something else that was talked about in relation to evidence. I don’t think the psychoanalytic community seeks to provide the sort of evidence that might be spoken of in the psychiatric community. However, the sole example that I will give, arose by virtue of this Conference. I would normally see a particular client at 12 o’clock on a Friday, but because I was going to be here, I arranged to see him at 9:30 yesterday morning. When he arrived he sort of apologised that he wasn’t really fully awake and that he felt he
maybe wasn’t speaking very coherently. I suppose I smiled to myself to a certain extent on that, because this is somebody whom I have been seeing for over two years and, with the exception of the first few sessions, when he focussed on what one might say were his immediate or main problems, he didn’t speak about them from then on. He has come to sessions for two years and spoken, almost without drawing a breath, about anything, but those problems. But he has, as Kim said - which I think is an important point - he has kept coming every single week. In a way, it’s a diary effect; he would talk about everything that had gone on during that week. But yesterday because, one might say, he wasn’t really totally with it, he spoke about a dream. This was only the second dream he had mentioned in two years. Also, he began to cry at one stage and, without going into too much detail, he said he thought that he didn’t feel he had very much longer to live because of his diagnosis. But you know, there wasn’t any real reason in relation to that because, in the context of his HIV he is healthy. And so, for me, that was, if you like, evidence of some emergence of the unconscious. That’s as far as I would go as regards evidence.

**Conall Larkin:** I have got a few very disjointed thoughts and most of them have arisen during this discussion. I suppose I happen to have the fortune or misfortune of being the last contributor. The first thing to say is that it has been a very enjoyable day. A meeting like this would not have been possible 30 years ago and I suppose it is a measure of how far psychotherapy in Ireland has come over a relatively short period of time. It was a dessert, quite barren in the 1960s, with the exception of the Monkstown group led by J. T. Hanaghan. It improved in the 1970s with the return of Prof. Noel Walsh from Canada and the work of Dr. Tom Freeman in Belfast who had a particular interest in the psychoanalytic theory of schizophrenia. But my first thought is really one of pessimism and has to do with psychiatric training in the last couple of years and what doctors are being taught and what it is possible to teach trainees. Part of it has to do with psychiatric training in the last couple of years and what doctors are being taught and what it is possible to teach trainees. Part of it has to do with the European Working Time Directive and, in my view, the negative effect it is having on the limited time trainees have to get involved in direct patient care and more importantly, continuity of care. Much of what they are being taught in psychiatry now is influenced by the DSM or ICD diagnostic manuals and precision around diagnosis. It does not take life experience and context into account which is necessary if there is to be a true understanding of the nature of someone’s symptoms. In the more severe psychotic illnesses there is, most likely, a biological basis whether it is structural, genetic or biochemical. In other cases of non-psychotic illness, it has more to do with one’s life experiences and background. The
phenomenology describes the symptoms, hallucinations in psychoses, anxiety or terror in panic attacks etc. In order to understand the content of the symptoms, I think you need some understanding of context, the background and what may have contributed to it. With the European Working Time Directive, psychiatric registrars now work shorter weeks. That comes with certain advantages, but it also comes with many disadvantages. They are just not available a full five days a week. So if you were running psychotherapy meetings or seminars, trainees are not available to attend, or if you are seeing patients it maybe is three days during the week. So, what is lost is continuity of care, of seeing patient’s on a day to day basis, listening to them and meeting their relatives. Trainee availability to participate in teaching sessions and psychotherapy supervision groups has become limited. There is great danger I think that the next generation of psychiatrists will not have the exposure that the current generation have had - thus my worry and pessimism in that regard.

The second thought has to do with the struggle that individuals have, especially with schizophrenia or bipolar illness, and that’s the struggle of acceptance of their condition. Several of today’s speakers have touched on this subject. And yes, the pills help, but many of them request psychotherapy, counselling or psychoanalysis. Part of it is the wish not to be dependent on medication, to be independent of therapists and anger about having this condition that has had such a negative effect on their life. There is a very good description of this struggle in Elyn Sachs book that has been referred to a number of times today. I listened to her talk and I met her before reading the book. I was fascinated how someone who is so intelligent would repeatedly throughout her life, just as her life was stabilising, stop taking her medication and within weeks or months end up acutely psychotic. I frequently see people with bipolar disorder who hope that through psychotherapy that they will come to a point where they will outgrow the condition and stop taking medication. Yes, psychotherapy helps greatly, but they do need that additional pharmacological assistance if they are going to stay well and avoid relapse.

After a number of decades working with individuals I am still struck by the power of the therapist-patient relationship. The power of this relationship is often not appreciated by some therapists or trainees in psychiatry. The trust that individuals place in the person they come to see and the influence that person can have over that person is enormous.
And my last thought was on - and it hasn’t come up much today - the whole concept of early intervention. Many people with schizophrenia are symptomatic for months or years before seeking treatment. This can have a serious effect on their education, social network, job prospects and finances. They lose out for many reasons during those months or years. In the region I worked in South Dublin, the duration of illness for people with untreated psychosis before DETECT (an early intervention programme for schizophrenia) was 2 years. Families would feel their concerns were ignored, and clinicians were frequently reluctant to openly discuss the diagnosis because of its implications. Valuable time was lost. That time period has now been reduced by the early intervention programme to a number of months. It makes a huge difference. I have seen, in recent years, people between the ages of 18 and 24 coming to hospital with their first psychotic episode where interventions were robust, thorough, and multidisciplinary, with rehabilitation, family education and cognitive behavioural therapy combined with appropriate medication to minimize side effects. By identifying and treating these conditions earlier I have seen patients returning to school, University, and to work - reaching a level of recovery and achievement that I certainly wouldn’t have seen in working with psychotic patient’s in previous decades.

Fiona McNicholas: I would just like to thank the panel very much. Your reflections on the day were very insightful and meaningful but also very personal, so thank you all. Despite the understandable pessimism we must have in our current economic and social situation, stimulating conferences such as these, allowing us to consider other possibilities and ways of working may actually activate us to do something about it. Opportunities already exist, the glass is half full already so if we keep that perspective, we know it will likely be linked to success. Just before I close perhaps I could also extend on your behalf our gratitude to Patricia for organising a wonderful conference and maybe if I could ask her to say a few words. After that we can give a buille bos for everybody.

Patricia McCarthy: Thank you, Fiona for so ably chairing the round-table discussion. This was always intended to be - from the moment myself, Noel Walsh and Mary Darby began to plan the event - a highlight of the day. It has proved to be just that. I want to thank all the discussants, the speakers and the chairs, all of whom entered into the spirit of dialogue demanded by the challenges we face in addressing the suffering of the seriously troubled people who come to put their trust in us. Let us conclude with a paraphrase which I hope won’t sound too aphoristic, given the
seriousness of our concerns, ‘Isn’t it better to debate a question without settling it than to settle a question without debating it?’. This we at least attempted today.
Thank you to everyone.
PAEDIATRIC BIPOLAR?

Lionel Bailly

Between 1994 and 2003 the number of outpatient pediatric psychiatry visits associated with the diagnosis of Bipolar Disorder in the USA apparently increased 40-fold. Such an increase was not supported by any new research evidence and illustrated a shift of professional towards a purely organic model of child behaviour. The preparation of DSM 5 showed a return to a more psychological model of disturbances in children with the introduction of a new disorder: Temper Dysregulation Disorder with Dysphoria. However, psychoanalytical models can provide a deeper understanding of the process leading to the observed symptoms.

Key words: Paediatric Bipolar; Temper Dysregulation Disorder with Dysphoria; paternal metaphor; enjoyment; psychoanalysis.

This presentation is going to be marked by my scepticism towards some aspects of what has been called Paediatric Bipolar, a Disorder that will not be included in DSM 5 and I’m going to try to justify this scepticism through the examination of clinical features described in children. This attitude is probably a consequence of my training as a clinician, a child psychiatrist and a psychoanalyst.

When one looks at the concept of Paediatric Bipolar, it is striking to realise that this currently important issue was hardly mentioned in child psychiatry fifteen years ago. The view that children may sometimes display manic defences or that they might react in a manic way to certain situations was accepted. In addition, some clinicians wondered at what age adult patients who suffer from bipolar disorder started to be symptomatic and if their condition might sometimes start during childhood. Then things changed radically. A growing number of professionals started to diagnose children as suffering from Bipolar Disorder and the concept of Paediatric Bipolar was created de facto. The DSM 5 child and adolescent disorder work group mentioned that the prevalence of paediatric bipolar increased forty-fold between 1994 and 2003 in the USA. Such an increase is problematic. It means that either the disorder wasn’t diagnosed and nobody realised that a large group of children suffered from bipolar disorder, or this label is a
new way of describing something else, which is not this particular mood disorder. An important fact is that apparently no new research evidence explained the rise in prevalence; this however did not prevent the development of many opinions about the subject. Although the child and adolescent workgroup of DSM 5 was doubtful about the concept of Paediatric Bipolar as a safe diagnostic label, the debate continues to be singularly polarised and passionate, as any internet search of the term Paediatric Bipolar will reveal. The concept appears to have moved beyond scientific committees into the public domain. As an illustration, Doctor Shafer who is on the DSM 5 childhood committee wrote that “maybe the practitioners will be such firm believers in that they will continue to use [the concept of Paediatric Bipolar]”. It is curious to see a scientist using the term ‘believers’ to explain some of her colleagues’ position. On the other side of the argument, John McNamee who on his blog says he is an “award winning mental health journalist and author” wrote: “It is fairly apparent that they [Mood Disorder workgroup] caved into the demands of the Child and Adolescent workgroup”. Again the use of an unexpected word in a scientific debate, ‘caving in’, as if the exchange was not scientific and rational but a show of political force.

It is important to underline at this stage that some socioeconomic factors appeared to play an important role in the debate. In the USA insurance companies decide if they pay for a treatment. Something that is not medical is unlikely to be paid for by a medical insurance and Bipolar Disorder is a clear and recognised entity that justifies the financing of its treatment. As Dr. Gabrielle Carlson, Child Psychiatrist at Stony Brook University says, "If you've got something that says it's not a medical problem, insurance is not going to pay for it... Conduct Disorder is bad parenting, lousy environment, poor supervision, you're a bad seed. It ain't a medical problem. Bipolar they'll pay for.” It is also important to consider that for drug companies, the change in attitude – or the creation of the category – entails the prescription of mood stabilisers to children, and the resulting increase in profits, when looked at on a planetary scale, would be phenomenal. In this debate we should consider the point of view of the parents of these children. Beyond the parents’ wish to understand what sort of problems their child has, there is also a more emotionally complicated aspect. Dr Gabrielle Carlson points out: “If it’s a bipolar, I’m off the hook, I’m not a bad parent it’s just a kid with a genetic problem, it’s not my fault”. An important part of an initial assessment with families has to do with this issue; is it something for which the parents are responsible? Beyond the psychopathological aspect of the question lie issues of guilt,
shame and the parents’ sadness linked to the collapse of their valued self-image. At this point, the debate therefore associates a lack of research evidence, the belief system of professionals, financial rewards, parents’ wishful thinking, the logic of health insurance and the marketing plans of the pharmaceutical industry. In among all this, the child and his/her best interest is missing.

The child and adolescent group of the DSM 5, who ‘won’ the argument over the Mood Disorder workgroup, introduced a new concept to describe some of the children who had been labelled Bipolar. One of the problems encountered by clinicians working with these children is that their mood can change rapidly and frequently even over the course of a day. This does not fit the usual pattern of mood changes in Bipolar Disorder, so they introduced the new concept of ‘ultra diem’ to describe these fluctuations. As a result, the vacillations of a child’s mood – common to all who observe children - may now be understood not as a feature of childhood but as a psychiatric symptom. Every child who loses their temper or becomes over excited is, according to this view, displaying a ‘mood episode’. In opposition to this controversial view, the child and adolescent group of the DSM 5 suggested a new concept of Temper Dysregulation Disorder with Dysphoria (TDDD). This is a disorder characterized by severe recurrent temper outbursts in response to common stresses. The behaviours include verbal rages, physical aggression, reactions grossly out of proportion in intensity and duration to the situation and responses which are inconsistent with developmental level. The temper outbursts occur on average three or more times per week. Between the temper outbursts the child is irritable, angry or sad. It could be argued that many children under the age of eight or nine behave in this way and that it is rather strange to label a miserable child who throws tantrums TDDD. However, it could also be seen as progress if the alternative is to say that they suffer from bipolar disorder.

It is important to try to move away from these rather simplistic medical models and it can be argued that the psychoanalytical model provides the tools to do so. In babies, there is an organic link between mental states and physical states: screaming, tight fists, contraction of the limbs in flexion… the observer knows that the child is hungry or in pain, or suffering in some other way. How does the carer know this? Because it’s the first thing babies can do to express themselves. They can’t tell their parents that they are hungry or in pain because they can’t speak or even hold their own head or move. They do what is developmentally possible, they scream and contract their muscles and get red in the face and that usually is enough.
The good enough mother or father makes an hypothesis about the child’s needs and acts on it. It is a primitive and limited way to communicate, but it’s not inefficient. At the beginning of life feelings are expressed by physical states. Unpleasant mental states cause tension and pleasant mental states cause relaxation. A hungry baby is very tense, the baby is fed and becomes less tense, starts to relax and finally falls asleep contented. This lasts for a few hours until the baby wakes up and becomes hungry again, creating cycles of tension and relaxation. Contraction of muscles remains the most archaic way of expressing feelings up to the adulthood. States of great joy and excitement but also of anger or fear provoke physical responses of tension not very different from what is observed in babies and toddlers. It can be seen sometimes as a regressive way of expressing feelings but is one that has been set at the very beginning of life and can be reactivated in certain circumstances.

Usually what happens during development is that the mother puts words to the child’s state. The baby is tense and the mother says, “look at you, you’re in such a state… it’s over… don’t worry”. This happens in an interaction between the mother and the child. The mother has to read or guess the child’s state. We might notice that the child is in a certain state and doesn’t know it, but the mother pushes the knowledge into the child, forces it in, in a way, she makes the child think: “Look at yourself, you’re in such a state”. That’s a statement and it’s a statement about the child made by somebody outside and this makes the child think. The process triggers a move from the physical to the psychological. This process can be called symbolization or mentalization and leads from an experience of a physical state to mentally recognising that state, to constructing a mental representation of that state that will later allow it to be thought about. If this process fails, the child is going to remain in a primitive state of tension and is going to continue to develop a style of reaction which involves physical states of tension and agitation and difficulties in thinking. The child will not learn to move away from archaic reactions.

Why might the process of mentalisation, which proceeds from the dialogue between the mother and the child fail? Many reasons could cause this failure. The mother might be too preoccupied to pay attention to the state the child is in because she’s depressed, is abusing drugs or alcohol… She could also not be interested in the child or be hostile to a child who was unwanted or who represents a now-hated partner. There could be violence against the child in cases of abuse, or the child may be initiated into violence purely by the mother’s projections: she interprets and describes
the child’s behaviours as being ‘exactly like his violent father’ even at an age where the behaviour described has a completely different meaning (hitting, pushing etc.). The mother might be overwhelmed by her task, she may think she does not have the skills to deal with the child and she doesn’t know what to do, in such a way that she is not going to read the child’s state. Alternatively, the mother might be delighted by a child that is for her so fantastic that anything he or she does is good and acceptable. This delight (and absence of boundaries in the mother’s mind) may fuel in the child a way of being where there is no limitation to enjoyment – and no recognition of when the child’s excitement is a manic defence against tiredness or anxiety, or is becoming actually wearing and painful. Lastly, the mother could have been through a traumatic experience of loss such as a cot death and may remain afraid with her new baby that this terrible experience could happen again. One can understand such a mother’s wish to see proofs of the child’s vitality. This attitude fuels a system in which activity is seen as a manifestation of health (being alive).

Most of the children for whom the mother has failed to read the child’s states of tension and failed to help him/her to move from physical states of tension to mentalisation are described by clinicians as manic or as suffering from ADHD. The behaviours described become the child’s usual style of reaction, the child’s most efficient defence mechanism and coping strategy. If a child starts to display these behaviours from a very young age, after some years it becomes almost impossible to distinguish the behaviour from a neuro-developmental disorder. The ‘manic’ pathway is usually used as a mostly unconscious strategy to cope with painful or challenging feelings by children for whom the process of symbolization of initial physical states has failed and in ordinary children faced with some very challenging situations (for example a difficult emotional environment such as parental separation, disharmony, the birth of a sibling who seems preferred etc).

Some psychoanalytical concepts can help to explain how the system described above can come into being. Firstly, let’s examine the concept of the paternal metaphor, the Name Of The Father in Lacan’s theory. The paternal metaphor is a process by which the child comes to accept a compromise regarding the satisfaction of his desire and his/her enjoyment. The child’s desire for a perfect, fusional relationship with the mother is dropped for the promise of something to aspire to. The child wishes that his/her primary relationship with the mother will know no end and no boundaries. There should be no interruption to cuddles, feeding, playing etc. - children always wants another minute of playing, another game or
another story. The child would like the mother to be an extension of itself — ever available and attentive to its needs and wants - but this, of course, is never the case.

The child soon starts to realise that the mother is not always present — neither in body nor in mind. This is a trivial experience, somebody rings at the door and she leaves the room. The child thinks, “I want her to stay but she goes…why?” Or the child notices that Mum isn’t playing ‘properly’ — doing exactly as it would like in a game — she is preoccupied, thinking about something else: “What is in her mind?” Lacan suggests that the child starts to realise that he or she is not the only object of his mother’s desire and starts to wonder, “What is the object of her desire? what is on her mind?” In the child’s self-centred logic, the mother leaves because she wants something that the child doesn’t have, as if he/she had it, the mother would not need to go anywhere else. This object is what Lacan, following on from Freud, called the Phallus, a mysterious object that is not of this world.

In Lacanian theory, the phallus is not the penis, the male organ, but is something far more powerful — it is the object of mother’s desire. The child thinks that when the mother is not present for him/her, it is because she is focused on that object. For the child the issue is how to deal with this fact, should he/she accept it? Should this attitude be allowed? Is this licit? Should she be allowed to do this, to leave me like this? The question of one’s desire - what one wants - is complex and intimate and one way out of this situation is for the mother to name something else, not exactly what she’s after in life generally (which she may not know herself) but to name some credible representative of her desire to explain her absence to the child. In the context of an infant, this representative is often the father of the child. When the father comes back from work and mother feels like spending some time with him, she communicates to the child that there is someone else in her life, that the child is not the only object of her desire. In most cases, the child will accept this fact: “Daddy” is not a bad excuse, especially as the child knows that it is also somehow very closely linked with him. The paternal metaphor is however, a metaphor — the father is a very useful and appropriate convenience to explain what else there is in mother’s life that holds her interest; but it may be anything else that preoccupies mother — her work, her social life etc. The name of the father is the metaphor for whatever it is that mother wants - the unknowable object of her desire - the Phallus. Importantly, Lacan insists upon the ‘name of the father’ and not the father himself, as what is important is that
the problematic for the child is expressed and resolved by the presentation of a word to signify something vast, abstract and unknowable.

Accepting the metaphor allows the child to ‘read’ his mother’s behaviours, when she is not properly focused on him/her, in a less persecutory and devastating way and to start forming hypotheses of its own; it also is a way for the child to develop an interest in the wider world that is so interesting to Mummy. However, it is, to begin with, painful for the child, because it involves, first of all, the recognition and admission that it is not the sole object of the mother’s desire, it is not/has not the perfect object (the phallus); this is a wishful fantasy that the child clings to and sometimes has every reason to believe in, especially if it has a mother who is genuinely very preoccupied and absorbed by it – sometimes it does feel like it does have the phallus. But with time, every child has to recognise that it is not, it cannot control mother, and also, that she is not in perfect control of the world: there is something beyond her from which rules and laws emanate, and she, like it, has to submit to this. Thus, admitting that it is ‘bedtime’ is in fact the equivalent of a statement recognising a law outside my control – and not emanating entirely from mother’s whim either - and to which I am subjected. The dyadic world of mother-child is broken by this mysterious thing from the outside world. The role of the father is to be a spanner in the child’s works of wishful fantasy. And Lacan says that the function of the father is to be a signifier substituted for the first signifier introducing symbolization, the maternal signifier. In other words, there is a conceptual progression from thinking about what the mother is after, the object of her desire, to accepting something present and named which represents her desire but is not its real object. By naming the father, (or whatever else she chooses to name) the mother is actually still naming the fundamental object of her desire, but through a symbolic process. By submitting to this symbolic process (accepting the metaphor), the child enters fully into the world of language and verbal reasoning, from which spring laws and the rules of social life. Because there is for both child and parent an unspoken knowledge that it is a metaphor, its acceptance sets a template for the child to develop its own system of metaphorical thinking, in which meaning is found in the associations between words and not in the concrete linking of words and objects.

Another important result of the child’s acceptance of the paternal metaphor - especially when the paternal metaphor does actually name the child’s real-life father - is that the child knows that its father does not possess the phallus and interprets the father’s engagement with the external world as
part of the eternal quest for it. The child recognises that father too belongs to the set of beings who are imperfect - without the phallus - but that part of being human is to be seeking the perfect object in the external world. Thus, the so-called ‘law of the father’ is one in which the child also accepts not just that it hasn’t got the phallus (is castrated), but that it belongs to a whole class of castrated subjects, and that perhaps it might be possible to acquire something of this mysterious phallus by its own engagement with the outside world. Thus, it becomes interested in natural laws, stories of heroes with a quest, princesses in danger, in word games and collectables, and finally, in learning. As you can see, for Lacan, castration is always a symbolic process of recognising one’s imperfection and not, as for Freud, anything to do with a genital organ or a threat to physical integrity.

Some children find it difficult to submit to the Paternal Metaphor and continue to fight what they experience as an unbearable demand - the demand to give up their primary narcissism, in which is tied-up their fantasy of omnipotence. Some cannot give up the fantasy that they do indeed possess the phallus, and this means that as they grow up, they never really become deeply interested in the external world as the arena in which they might find it; they never invest emotionally in the enjoyment of discovering natural and social laws, but remain very self-centred and experience the imposition of laws and rules as persecutory. They resent and reject the covenant into which they feel they have been tricked. The parent tries to impose boundaries and the child responds with rage, which can sometimes lead to a tantrum during which the child, rejecting the symbolic and metaphorical systems of logic and reasoning, regresses to its archaic states of physical tension.

Another idea that is quite useful in understanding why children act in a manic way is the concept of enjoyment. This is another concept developed by Lacan, which separates a mode of functioning that is very specific to the individual from the concept of pleasure. It describes the way in which an individual relates to his/her psychological objects and specifies the functioning of a particular subject. There are different forms of enjoyment. One form Lacan described relatively late in his work is the enjoyment other or enjoyment of the other. This form of enjoyment is very archaic, involves the body and is without boundaries. To understand it, think of an infant enjoying the physical aspects of its relationship with its mother - the way a baby continues to want to suck, or to fall asleep with the nipple in its mouth, long after the need to satisfy hunger has been disposed of. This sort of experience - ‘enjoyment of the other’ is such that the individual would
like it to continue in an unending way. Later, the child is introduced through socialisation to another form of enjoyment, Phallic enjoyment, which involves the understanding, acceptance and application of laws. This is when the child moves from playing with mud to being interested in planets and dinosaurs and verbal jokes. Some children resent this move and fear that renouncing the ‘enjoyment of the other’ will mean being left without any enjoyment at all. These children are usually those who are having difficulty in accepting the paternal metaphor - they cannot quite give up the wish to be in perfect control of their objects and the fantasy of omnipotence that comes with it. They have not yet internalised the notion that accepting rules and laws and understanding them could be a source of great power. They cannot yet see what Phallic enjoyment can do for them in the widest social context.

It is important to take into account the notion of enjoyment, as well as the idea of the symbolic castration, in order to understand a child’s manic behaviours - the neglect of this aspect often makes children’s behaviours incomprehensible. Indeed, it is often the mother’s failure to address this issue of enjoyment (because she is enjoying it too much herself or fears that trying to curb it will somehow reflect badly on her) and the need to put limits on it that fuels the system whereby the child becomes habituated to very high level of ‘other enjoyment’ and becomes resentful of any attempt to limit it. If a child tries to remain functioning at the level of the ‘other enjoyment’, then every situation that should lead to phallic enjoyment is experienced as a threat. Wishing to stay in a certain style of enjoyment stops the child from moving on, maturing, getting more sensible, more sociable etc. It is often easy to observe this difficulty when children move from nursery to primary school. There they are expected to start to learn to read properly and many children labelled dyslexic have in fact very strong reservations about reading. They anticipate that once they learn how to read, they are going to lose their bedtime stories read to them by Mummy, and more generally, that they will be expected to learn things and know them for themselves, rather than having this knowledge permanently and phantasmatically carried about for them in the mind of an ever-present Mummy. There is indeed a loss in moving on to phallic enjoyment, but that loss is unavoidable. Children who try to preserve their other enjoyment against social demands tend to appear agitated, immature, easily angry, emotional… and can be seen by some clinician as having a mood disorder.

To conclude, I would like to say that in most cases the label paediatric bipolar actually describes the reactions of children who rebel against the
limitations of their enjoyment and the social pressure to move from the ‘enjoyment of the other’ to phallic enjoyment; they actively fight the concept of law as instituted by the paternal metaphor and they have failed to mentalise physical states of tension in early childhood. The concept of Temper Dysregulation Disorder with Dysphoria does not represent any great progress in the understanding of the nature of these children’s problems - but has the advantage of locating the pathology not in an organically disordered mood but in the field of emotional regulation. An interesting point in this new psychiatric category is the fact that the temper disregulation is linked with dysphoria. This aspect can be read by the analyst as a suggestion that the child has an unconscious knowledge that his or her position will be untenable in the long term. It is an anticipation of the radical loss that will be necessary to submit fully to the law of the father, to move towards phallic enjoyment and to start mentalising unpleasant physical states.

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Psychotic Symptoms– Time for a New Approach

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Previously-held ideas about the intrinsically pathological nature of hallucinations and delusions are being challenged by findings from epidemiology, neuroimaging and clinical research. Population-based studies show that the prevalence of psychotic symptoms is far greater than had been previously considered. Therefore it may be timely to re-evaluate our perspective on these psychotic symptoms and their meaning in an evolutionary context. These symptoms may hold the key to understanding the persistence of psychosis in the population. We discuss how these findings also have implications for the public perception of stigma and the development of new therapies that directly engage with the psychotic symptoms. These therapies have the potential to increase patient satisfaction with treatment, increase adherence and ultimately lead to better outcomes.

Keywords: psychosis; psychotic symptoms; evolution; hallucinations; psychotherapy

Nothing in biology makes sense except in the light of evolution.
Theodosius Dobzhansky¹

Hallucinationary experiences are as old as humankind² and, until the nineteenth century, these experiences were generally attributed to mystical sources such as gods or demons.³ Esquirol (1845)⁴ first proposed the use of the term hallucination as it is currently understood, making a distinction between normal sensory experiences and ‘pathological’ hallucinations. Over the twentieth century, hallucinations have generally been regarded as

⁴ Esquirol (1845) Mental Maladies: A Treatise on Insanity, New York: Hafner 1965
discontinuous with normal experience and as signs of medical illness. Recently, however, our ideas about hallucinations and delusions are being challenged by findings from epidemiology, neuro-imaging and clinical research. A new viewpoint is emerging. Simply put, hallucinations and delusions are commoner than we think. Population-based studies using both self-report and interview surveys show that the prevalence of psychotic symptoms is far greater than had been previously considered, with a recent meta-analysis suggesting a prevalence rate of 5-8% in the general population - about ten times higher than the prevalence of diagnosed psychotic disorders.\(^5\)

In this piece, we wish to re-evaluate our perspective on these psychotic symptoms and their meaning in an evolutionary context. These ‘non-clinical’ symptoms or experiences may hold the key to understanding the persistence of psychosis in the population.

**Taking an evolutionary perspective**

Psychosis is highly heritable and exerts strong negative fitness effects. Despite this apparent disadvantage, schizophrenia maintains a relatively stable prevalence worldwide (median prevalence varying between 4.6 and 7.2 per 1000 persons). Several theories drawing on the Darwinian paradigm of selective advantage have been formulated to explain the persistence of psychosis in the human population. Crow’s ‘speciation’ hypothesis\(^6\) argues that psychosis is the ‘price that homo sapiens pays’ for development of language, while Polimeni and Reiss\(^7\) have argued that psychosis genes may play an important role in human sociability. Burns\(^8\) proposes an alternative theory that schizophrenia is a ‘costly by-product in the evolution of complex social cognition’ and Nesse develops this idea in terms of ‘cliff-edge’ fitness, whereby certain traits may increase fitness up to a critical threshold, but beyond this threshold, fitness falls in a catastrophic

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manner. For instance, strong tendencies to use meta-representation and ‘theory of mind’ increase the ability to predict other people’s behaviours and how they might be trying to manipulate you, but, as Nesse explains

> it is only one step further, over the cliff’s edge of psychotic cognition, as it were, to finding secret meanings and evidence for conspiracies in other people’s most casual gesture.\(^9\)

It has also been proposed that certain types of hallucinations could be viewed as evolutionary by-products of a cognitive system designed to detect threat.\(^10\) For example, it would be far more deleterious to fail to recognise a threat such as the sound of an approaching predator (a false negative) than to mistakenly believe that a predator is approaching when it is not (false positive). Thus, the Darwinian model of evolution may favour a selective skew towards propagation of genes that promote false positives over false negatives, resulting in ‘hypervigilance hallucinations’ in the population. In social or pack animals, like humans, hypervigilance is not necessary for every member, but the presence of this trait in at least some members stands to benefit the entire group. Such a trade-off allows the persistence of advantageous traits even in the presence of increased risk of disorder. The possibility that vulnerability to psychosis may be a by-product of ‘normal’ human brain evolution, may offer an explanation for the difficulty in locating any genetic ‘point of rarity’ between individuals with schizophrenia and controls, and may help to reduce the stigma attached to psychotic disorders in the public imagination. Similar findings of higher-than-expected prevalences have also been reported for depression and anxiety.\(^11\) As Moffit points out,

> ...it might be time to stop asking how surveys can achieve acceptably low rates of disorder. Instead researchers might begin to ask ...what this prevalence means for etiological theory, ...service delivery

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policy, the economic burden of disease and public perceptions of the stigma of mental disorder.  

A developmental perspective on psychotic symptoms

It is becoming increasingly clear that a sizeable minority of young people report psychotic symptoms. Kelleher reported that auditory hallucinations were much commoner than delusions in a sample of 11-13 year old children. The commonest type of auditory hallucination was *gedankenlautwerden* or ‘thoughts spoken aloud’. This profile differs from adult populations and behoves us to consider a developmental aspect to the phenomenology of psychosis. A further issue is that questionnaires using items from interview schedules designed for adults may not be the optimal way to elicit psychotic symptoms among young people. There is a need to develop psychosis screening instruments designed specifically for younger age groups, such as the Auditory Vocal Hallucination Rating Scale which has been adjusted to suit 7-8 year old children.

Hallucinations are not necessarily pathological

Hallucinations may be caused by a wide range of somatic disorders, and a variety of medications and physiological conditions, but are also reported in individuals with no diagnosable illness and no evidence of functional decline. Functional neuro-imaging studies have demonstrated a distributed network of cortical and subcortical areas involved in the experience of hallucinations - the primary and secondary auditory association areas have been shown to be involved in auditory hallucinations in many (though not all) studies examining this issue. In other words, the disturbance seems to be more related to interpretation of stimuli than to perception itself.

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15 A. Aleman, F. Laroi, op. cit.
Implications for treatment

The ‘normalizing’ effect of the epidemiological, evolutionary and neuro-imaging approaches to psychotic symptoms as outlined in this piece have important implications for our treatment approach to hallucinations and delusions. The controversy that accompanied the Chestnut Lodge outcome studies and the subsequent Osheroff case had a negative effect for many years on the use of psychological treatments in psychosis. Medication became the cornerstone of treatment and talking to patients about their symptoms or attempting to construct non-biological explanations for symptoms was discouraged. Instead, many textbooks taught the need to confront psychotic patients with their reality-testing ‘deficit’. However, since one of the central aspects of delusions is that they cannot be corrected by reasoning, confrontation - by definition - does not stand a chance. Of course, some degree of confrontation is needed for establishing a proper diagnosis. But, from the very moment the delusion has been established, direct and overt confrontation becomes harmful. Firstly, defending one’s belief system is a basic human characteristic and wrongly-timed confrontation may re-inforce delusions unintentionally. Secondly, at some point of the debate, deluded patients may incorporate their (confrontational) therapist within the delusional system, damaging the therapeutic relationship. Drop-out from treatment is then almost inevitable. Voice-hearers report feeling personally rejected by direct confrontations. They blame therapists for not really listening, for not taking them seriously. They want therapists who are willing to listen to these strange experiences that they themselves do not understand, can neither explain nor effectively articulate and may find frightening, certainly in the beginning. The more we try to convince them that their experiences are merely pathological symptoms of an underlying mental disorder, the higher the risk that they may feel that they are misunderstood and that their experiences are being neglected. From this perspective, patient non-compliance becomes an understandable reaction to an unproductive therapeutic approach.

Indeed, Stephane et al.\textsuperscript{18} reported that answering questions about their symptoms for a research study seemed to help the participants.

*Asking patients for detailed description of their hallucinations does not seem to be part of routine practice of general psychiatry... In this study, most patients welcomed the opportunity of talking about their experiences and this procedure seemed to enhance the therapeutic alliance. Therefore such questioning should be encouraged.*

Finally, it has been shown that the main difference between voice-hearers with and without a psychiatric disorder is not the specific characteristics of the voices - for example third person or not - but the assignation of negative attributions to the voices and the feeling of lack of control or mastery of the voices.\textsuperscript{19, 20} Jenner\textsuperscript{21} found that 50-75\% of voice-hearers reported hearing ‘positive’ voices that help them against ‘negative’ ones. Fear that treatment will make these helpful voices disappear is another important reason for non-compliance.

**New psychological approaches**

Fortunately, over the past decade psychological treatments for psychosis are slowly emerging into the mainstream of treatment to complement and enhance the effects of medication. One of the first to emerge was problem-oriented family treatment, which significantly diminishes relapse and re-hospitalization rates in schizophrenia patients by about 20\%.\textsuperscript{22}

\begin{itemize}
\item G. E. Hogarty, C. M. Anderson, D. J. Reiss et al., ‘Family Psychoeducation, Social Skills Training and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia: II Two-year Effects of* 
\end{itemize}
Cognitive Behavioural therapy (CBT) for psychosis has gradually gained acceptance and has proved to be particularly effective for delusions. The primary focus of CBT is changing interpretations and attributions of psychotic experience and belief. The assumption is that changing attributions will reduce anxiety, depressive symptoms and desperation and will increase control and the feeling of mastery and self-competence. As a result, patients may have a better quality of life irrespective of their level of psychotic symptoms. Socratic questioning is a powerful method for changing attributions. Socratic questioning avoids direct confrontation and the therapist helps the patient to draw on his own doubt and experience in order to realise that there are other ways in which he is able to make sense of his experience.

Hallucination Focused Integrative Treatment (HIT) has a similar effect size as CBT on positive symptoms but with a main effect on hallucinations, and significant effects on depression, anxiety, disorganised thinking and subjective burden in both chronic patients and first episode adolescents. Improvements are maintained at follow-up assessment. In HIT there are a number of different modules incorporating motivation, coping training, CBT, psycho-education, medication and family treatment. Both patient and relatives receive cognitive interventions and training. Hallucination Focused Integrative Treatment takes a ‘two realities’ approach in that it accepts auditory vocal hallucinations as real

experiences existing besides our own experiences (Jenner in press). Patient satisfaction with the ‘two-realities’ principle is high and may be associated with the relatively low drop-out rates in HIT studies (10% -16% versus 30% -70% in medication studies and about 40% in CBT studies). The elevation of the patient to the role of ‘expert’ improves co-operation and compliance with homework tasks.

**Conclusion**

Studies showing that psychotic symptoms are present in a sizeable minority of the general population should have implications for the public perception of stigma of psychosis and the development of new therapies that directly engage with the psychotic symptoms. These therapies have the potential to increase patient satisfaction with treatment, increase adherence and ultimately lead to better outcomes. From a neuroscientific point of view, detailed investigation of the non-clinical psychosis phenotype should provide novel leads for etiological research in psychosis.

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Good morning ladies and gentlemen and welcome to our conference. My task is very simple and pleasant - to welcome you all. Let me begin by congratulating Dr. Patricia McCarthy for organising with our committee, this very interesting conference. I’m not going to mention all the Irish speakers by name, but just to say a special word of welcome to Dr. Bailly who is a French Psychoanalyst - you’ll be hearing from him later - and also to Professor Daniel Burston from Duquesne University, Pittsburgh. And also to say welcome to Dr. Cormac Gallagher who was a co-founder of the School of Psychotherapy and has made a very important contribution to psychotherapy and psychoanalysis especially Lacanian psychoanalysis here in Ireland.

Just a few words about the conference itself. It seems to me, as a retired Professor of Psychiatry, there has been, if you like, an either/or kind of attitude when it comes to the approach to mentally ill individuals. Either you favour biological treatments of therapy or, by contrast, psychological modalities including psychotherapy, psychoanalysis. So there is a dichotomy, but I would like to suggest that it should always be both. And in particular as the issue of bipolar is under discussion today, this problematic condition is a good example. We know that certain medications, for example, lithium is of importance. And in severe or depressive phases of bipolar, some experienced psychiatrists will say that the use of electroshock therapy can be life-saving, even though it’s a controversial treatment at the present time. So all I am suggesting is that far from having this dichotomy of either/or, it should be both pharmacological treatment and psychological treatment so that this divide, which seems to be gaining ground, is avoided in the patients interests. So with those few introductory words, I’ll turn over to Tony Hughes who is the Chairman for the first session. Thank you very much.
Evidence–based practice and psychoanalysis: thought disorder and the dream

Patricia McCarthy

Post-modernism, quantum theory, psychoanalysis-buzz words of the twentieth century likely to be misunderstood by the non-specialist – are domains that are governed by abstract sets of laws whose effect cannot be predicted and, into which, participants have to make their way. To acknowledge such domains is to broaden the definition of science and perhaps allow for a better understanding of one of them - psychoanalysis, which is governed by the laws of the unconscious. Freud discovered these laws, Lacan formalised them. How they work is the ‘evidence base’ of psychoanalysis which uniquely serves subjectivity and thereby excludes the objectifying eye of measurement. My argument is that to ignore this ‘evidence base’ is a loss to psychiatry and psychiatry’s patient – especially the psychotic. The implications of this loss will be further discussed by examining the parallels between thought disorder and the process at work in forming that simple ‘given’ of our psychical lives – the dream, continuous as it is with waking thought.

Keywords: evidence-based practice; quantum theory; thought disorder; the dream; subject–effect; schizophrenia

In the half hour allocated to me to speak to you, I am confronted with an immediate difficulty. In addressing a mixed audience of psychoanalysts and psychiatrists I am aware of the gaps in knowledge that define both groups differently. To impute a gap in knowledge to such august groupings is to risk alienating both sections of my audience all at once, but of course that is not my intention on this April Fools’ Day\(^1\) where it has already emerged so far from the papers and the questions arising, that the gaps in knowledge displayed are more badges of honour, equivalent to the participants, like knights of old, having handed in their individual weapons.

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\(^1\) This talk is part of the proceedings of a conference *Treatment Challenges in Bipolar Affective Disorder: Voices of Difference – Psychiatry and Psychoanalysis in Dialogue* held at St Vincent’s University Hospital, Dublin on Friday, April 1\(^{st}\) 2011
of knowledge at the registration desk this morning and trusting that they will emerge unscathed at the end of the day.

An example of this non-equivalence in epistemic systems was highlighted for me in a conversation I had, a few weeks ago, with Professor Fiona McNicholas when she asked me - What is the evidence base for psychoanalysis? The gap, no, the chasm, in differing comprehensions loomed large there and then. In consequence of Fiona’s very reasonable question from a psychiatric viewpoint, the challenge I’ve set myself today is two-fold; firstly I will attempt to answer it. This will hopefully permit further dialogue allowing me to broach my own question of psychiatry – If thought disorder - the symptom in psychiatry which can afflict both the manic and the schizophrenic - has an equivalence with aspects of the dream work, as formulated by Freud, how can it be that the dream, a normal psychical process does not engender any curiosity whatsoever on the part of psychiatry for what it might yield toward better understanding the concept that thought disorder is simply a way of thinking?

Quantum physics, uncertainty and chance
While researching the question of evidence-based practice and why psychoanalysis in its practice doesn’t hold it in esteem, I kept being drawn to John Gribbin’s book In Search of Schrödinger’s Cat: Quantum Physics and Reality, published in 1984. For the non-specialist this book remains an historical and very human account of the dramatic birth early in the last century of quantum physics and the dramatis personae involved, Max

Evidence-based practice, with its reliance on the Randomised Control Trial (RCT) as the gold standard, has been in the ascendancy since the 1990’s and is described by David Sackett as ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’. For a balanced account of the limits of evidence-based practice, I refer the reader to an editorial by Richard Laugharne in (‘Evidence-based Medicine, User involvement and the Post-Modern Paradigm’ Psychiatric Bulletin (1999), 23, 641 – 643): ‘In psychiatry, the necessity of measurement has led to a proliferation of rating scales – scales for mood, psychotic symptoms, even of strength of spiritual belief and loneliness. One for the reasons for the success of cognitive therapy has been in demonstrating its effectiveness through the use of rating scales’. While Laughnane acknowledges the ‘vital role of evidence-based medicine’, he argues that psychiatry risks leaving ‘the human side of mental health care to colleagues in other professions (who are then accused of not being evidence-based in their work)”

Putting it less contentiously, psychiatry is a science of the universal whereas psychoanalysis is a science of the particular.
Planck, Niels Bohr, Werner Heisenberg, Paul Dirac and Erwin Schrödinger. Schrödinger, of the book’s title, you may know, was invited to Ireland after the Anschluss by the then Taoiseach, Éamon DeValera to help set up the Institute for Advanced Studies. He lived in Clontarf, spent seventeen years as Director of the School of Theoretical Physics and eventually took out Irish citizenship. Chronologically, you may also know that the discoveries of quantum physics or mechanics, come after Einstein, whose own discoveries we equally recognise as pretty extra-ordinary. Einstein gave us the special theory of relativity, a theory that essentially defines ‘relativity (as) a state of dependence in which the significance or existence of one entity is solely dependent on the variability of another entity’. But then along came quantum physics, defined by Gribbin not as a branch of science, but rather the underpinning of all modern science—a definition that uncannily echoes Freud’s and every analyst’s contention that the laws of the unconscious ‘govern all thought and all psychology has these laws at its foundation’.

_The mathematical equations of this domain (of quantum physics) provide the only understanding of the world of the invisible, without which physicists would be unable to design working nuclear plants, build lasers, explain how the sun stays hot. Without quantum mechanics..there would be no science of molecular biology, no understanding of DNA, no genetic engineering – at all._

Gribbin goes on the say that quantum theory is far more significant than Einstein’s theory of relativity. Einstein believed that uncertainty wasn’t really uncertainty at all and that there was, in fact, an underlying reality in which particles would have well defined positions and speeds and would evolve according to deterministic laws. But quantum theory concluded otherwise. From studying the position and momentum of virtual particles, it began to dawn on these pioneers that their inability to measure these variables was to do with the system itself and that, in fact, _randomness was_

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4 In speaking about the ‘science’ of psychoanalysis, it is not my intention to limit the definition of science, again quoting Laughnane (see footnote 2), to the modernist view of reality as ‘rationalist, materialist and reductionist’. In that sense, I fully subscribe to Lacan’s definition of science as ‘delusional’ if it is based on an objectifiable notion of truth or the attempt to equate subjectivity with a measurable entity.

defining reality. And this, according to Gribbin, is where quantum theory cut(s) free from the determinacy of classical ideas. This led Heisenberg, in the twenties, to invoke the principle of uncertainty and famously say ‘we cannot know as a matter of principle, the present in all its details’.

More famously, Einstein, when confronted with this notion that essentially random ‘choices’ of possibilities at the quantum level decided reality, said ‘God does not play dice with the universe’. This, coupled with Niels Bohr’s statement that ‘anyone who is not shocked by quantum theory has not understood it’ sums up the state of play for this theoretical minefield - more metaphysical than physical in its concerns - that had such philosophical implications as to have induced a degree of horror in the participants.

About the field, Schrödinger is reputed to have said: ‘I don’t like it, and I’m sorry I ever had anything to do with it’. This high-church of conjectural science evokes a sense in us that theory such as this is indeed beyond us and further and importantly for the current debate, we would consider it ludicrous to challenge such a system to reproduce the results of chance encounters and submit them to systematic, verifiable, generalisable systems. Because quite simply, the laws of chance do not lend themselves to reproducibility. In similar fashion, psychoanalysis cuts loose from reproducibility because the working of chance is at the heart of its practice: and this is the main point I wish to make in speaking about quantum physics and psychoanalysis on the same page. Likewise, psychoanalysis - as an epistemic domain governed by an abstract set of rules that participants have to make their way into - has the same demand to be as respected as the field of quantum physics. And, as in quantum physics where randomness defines reality, psychoanalysis holds that the continuous working of chance at the heart of the analytic enterprise shapes subjective reality, making it a unique transformative process. In the same breath

\[ \text{Again on questioning the definition of science, the algorithm for the working of the laws of the unconscious is } S_i \rightarrow S_j / S. \text{ Heisenberg’s mathematical equation for the uncertainty principle in quantum mechanics is } pq - qp = \frac{h}{i}. \text{ None of us would pretend to say we understand how such a formula works, whereas the psychoanalyst does understand how } S_i \rightarrow S_j / S \text{ works! In a much simpler vein, as taught to my generation by the teacher of Lacanian psychoanalysis in Ireland, Cormac Gallagher, when an apple falls from a tree we observe that as ‘gravity’ at work, which Newton mathematicised as } f = G(m_1 m_2 / r^2). \text{ The apple falling is an empirical discovery, leading to the necessity of understanding the general characteristics of the laws governing this so-called natural process. Science demands that mathematical models are developed which separate natural processes into theoretical-mathematical formulae or algorithms. Rather than relying on simple observation, events must satisfy the mathematical model or algorithm.} \]
however, this reference to subjective reality,⁷ again marks the absolute difference between science in the classical Cartesian sense - ‘where a thing is a thing... or an electron is an electron’⁸ - and psychoanalysis, in contrast, which works with phenomena in the Kantian sense, as the following section tries to illustrate.⁹

A clinical example
In the analytic setting, there are two participants, the analyst and the analysand or analyser – to use Jacques Lacan’s more fitting term, coined by him in the seventies. Neither analyst nor analyst knows in advance what the outcome of an analysis will be. In an analysis something happens in real time; a happening that demands an absolute requirement for an ideal set of conditions. When these are not there, the subjective happenings do not take place.

In analysis then, Freud’s free association, the rule of non-omission allows chance to operate. Putting it a bit simplistically, the activity in an analytic session is as follows: the patient speaks about whatever passes through their mind at the time it comes to mind. In being introduced to analysis, the patient is informed that dreams have a privileged place in the work. Let’s consider the patient who, after some time, has indeed begun to get the sense that dreams are somehow linked with their conscious thoughts. Typically the patient will speak about their latest dream at every session. In the session, this free association, the act of putting words on the images that are passing through your mind, in the presence of the analyst, be these of dreams or other matters, is a business that is quite unlike ordinary discourse. You, the analysand, become aware that you are not quite master of what you had planned to say, because other thoughts present themselves seemingly unbidden, which, when spoken about, have an effect, a subject–effect which is of the moment and cannot be anticipated in advance. Surprise and revelation are the terms that best describe this process. During the act of putting words solely on what is thought, new thoughts occur to you which give rise to new associations, and new meanings dawn. And the analyst? Yes, the analyst, as a witness is listening too, and out of that listening may or may not make an interpretation.

⁷ See footnote 4
⁸ As quoted by the reviewer of this paper, Christian Fierens, who encouraged me to further emphasise the difference between science and psychoanalysis.
⁹ Esoteric stuff, I accept, but of crucial importance to both sides of our dialogue today.
By way of example, a woman doing an analysis has the following dream:

*My neighbour is moving house. I’m there with her in the house she’ll be leaving, standing beside her, looking out her kitchen window at the back garden. I comment that she must be sorry to leave, after all the work she has put into the garden over the years. I see the four trees she planted when they first moved in.*

She went on to speak about the fact that she herself has not yet moved out of home and that her mother makes her feel guilty about ever doing so, particularly when she says ‘you’ll miss me when I’m gone’. She continued to say that her maternal grandmother frequently used the same expression, as did her aunt (her mother’s sister). I asked her to say a little more about her mother’s family and she went on to recount that this grandmother had married a widower who had four children by a first marriage and who then went on to have four more children with her. I pointed out that this *four* of the two families was already presented in her dream of the *four* trees. With no regard for syntax or sense, I plucked the *four* of the four trees from its dream context and aligned it now with the two families of *four* children on her mother’s side of the family. I disordered the ‘sense’ so to speak. This implicitly conveys that there is an unconscious thinking going on that the analyst must signal to the analyser, it follows its own logical rules that do not follow the path of sense, and it is somehow ahead of the game. *I’m now asking you, the listener where do you think the *four* of the dream comes from?* The *four* of the dream is not in itself remarkable in any way nor does it ‘stand out’ unless the second reference to the two families of *four* emerged beside it in the same session.

The concept of contiguity or relatedness (which has echoes of Einstein’s definition of general relativity mentioned in the last section), is central to Lacan’s definition of the signifier, the signifier being what represents the subject for another signifier ($S_1 \rightarrow S_2/\$). Again, this is simply illustrated in the clinical example by the four trees which without the later reference to a

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10 Again I am grateful to Christian Fierens for reminding me of Lacan’s play on words in *l’Etourdit*, between *évidemment* (evidently) and *évidement* (to empty out), where the analyst interferes with language by emptying out the sense; my use of the word *disordered* to describe this interference was deliberate in light of the topic of my paper - see later section on Bleuler and Freud: *thought disorder and the dream*, where the latent content of the dream, as disordered prior to the dreamwork is described.
family of four – which without being re-presented - would not have the special effect of illumination or ‘sign-posting’ to something, something yet to come. To have simply highlighted this connection has an effect, the direction of which is utterly of what the unconscious thinking on the patient’s side will go on to produce in tune with the patient’s subjective truth. This is the Lacanian signifier at work. This discrete element of language - the dream was of four trees, not three trees or five trees - has nothing ‘wishy-washy’ or ineffable about it; for the analyst, rather than being the gold standard of the Randomised Control Trial(RCT), it is an emerging seam of gold leading to a continuous generating of a subject-effect. This makes for all possible difference between therapies based on insight, behaviour modification, conscious realization etc, all of which are based on suggestion in one guise or another (including of course interpretation of the transference!) and a therapy, like psychoanalysis which is based on working with formations of the unconscious or continuing chance encounters between emerging signifiers.

Three further incompatibilities posed for psychoanalysis by the measuring of effect

I want to say a little more about subject-effect in psychoanalysis from a few different angles to highlight the incompatibility of measuring such a thing. In the 2006 Irish Government document on mental health A Vision for Change, there is a very interesting passage on the concept of social capital and how it contributes to breaking the cycle of social exclusion. Social capital is associated with positive gain and can often be an unseen side-effect of other activities.\(^{11}\) For example, membership of a football team or sports club conveys much more than the benefits of physical exercise. The sense of belonging and the social contacts and support from such a group can be equally important, but difficult to identify and measure. And it is here that there is a difference between the social scientist’s priority and the psychoanalyst’s priority. The measurement of social-effect in the context of belonging to a football club typically becomes the object of a scientific study, which in turn takes its place as part of an evidence base. But subject-effect in psychoanalysis, is its sole raison d’être and cannot be turned into the object of a scientific study - because once that becomes the agenda, it is

simply no longer analysis but something else, - laudable in the social science context - but inimical to psychoanalysis.

The concept of observer effect allows me make a further point. At the end of the nineteenth century, when the early anthropologists first went on their field trips to South America and places such as New Caledonia, they quickly found out that when a living human community was observed, no matter how discreetly, the prior conditions changed. And when they tried to overcome this by themselves ‘going native’ and becoming part of the community, the original ‘object of study’ could no longer be restored to its original ‘unobserved’ status. No such risks can be taken in psychoanalysis, where the analyst is a listener not an observer, and where an intensely human activity proceeds according to certain laws. Safe to say that the topic of what to do with effect is at the heart of a much bigger debate within analysis itself that I won’t have time to go into here. Except to add that ‘doublethinking our way to “scientific” legitimacy’ or doublethinking our way to providing an evidence base, as currently propounded by Peter Fonagy et al, is not an option for psychoanalysis!

Another perspective on the relationship psychoanalysis has to the empirical method is provided by Roger Perron writing in 2006 in The International Journal of Psychoanalysis.13 The concept of the unconscious that we keep talking about is a general hypothesis, rather than a local hypothesis where, in the context of an experimental approach in the narrow sense, Popper’s rules of reproducibility and falsifiability are justified. Regarding a general hypothesis, no one requires Newtonian theory to be formulated in terms such that it can be destroyed by a new finding. Likewise Darwin’s theory of evolution or indeed what we were talking about earlier - quantum physics. Similarly, a general theory such as the dynamic unconscious is either useful to you or not. As Perron goes on to say

You are perfectly entitled to do without the hypothesis of a dynamic unconscious (or infantile sexuality or unconscious phantasy etc) but you then lose the possibility of understanding many facts that can be understood only by having recourse to this hypothesis.

He concludes ‘your phenomenal\textsuperscript{14} field is (then) singularly restricted’. Now most of us sitting here don’t mind this restriction to our phenomenal field; we don’t even know it is restricted; we’re doing fine thank you very much. Except of course, if we have responsibility for patients, where surely it is a significant matter if this restriction in your phenomenal field impinges on that fact. That, I respectfully propose, is something that psychiatry should revisit in the light of any awareness that there are specialist practitioners of this phenomenal field.

**Bleuler and Freud: thought disorder and the dream**

Coming to the second part of my talk, I’m going to further try to illustrate how the fact of the unconscious might be significant, by examining the views of two great contemporaries of the last century - Bleuler on thought disorder, the hallmark symptom of schizophrenia and the manic phase of bipolar disorder, and Freud, on the dream, that paramount indicator of unconscious thinking.\textsuperscript{15}

**Bleuler on thought disorder**

Taking a random sample from his classic textbook, first published in 1908, *Dementia Praecox or The Group of Schizophrenias*,\textsuperscript{16} Bleuler gives the following brief example of thought disorder, as it comes through in a letter written by a catatonic patient. He begins this demonstration by saying

\textsuperscript{14} Phenomenal, not in the colloquial sense of ‘remarkable’ or ‘extraordinary’, but in the philosophical sense of ‘known through the senses rather than through thought or intuition’.

\textsuperscript{15} The absolute continuity between the dream and waking life is a psychoanalytic given, immortalised by Freud as follows: ‘(dreams) are not meaningless, they are not absurd; they do not imply that one portion of our store of ideas is asleep while another portion is beginning to wake. On the contrary, they are psychical phenomena of complete validity – fulfilments of wishes; they are inserted into the chain of intelligible waking mental acts; they are constructed by a highly complicated activity of the mind’ *The Interpretation of Dreams* SE vol 4 (1900), p 200

It is not unusual for a piece of writing to founder in a mire of uncontrolled associations. Thus a catatonic who was delighted when we ordered her to write home concerning her eligibility for release, wrote as follows:

R. (her home address, instead of the hospital’s)
27 April 1887 (Actual date 1906)

Dear Parents,

Be so kind and come and get me my sister washed for me and we must to kitchen
(born 66)

From your sister, L.S.

The patient’s lack of purpose and appropriate thought is shown in the many deviations from the starting ideas: both the content and the sound of words lead them astray...

Inconsistencies, such as the above, where the letter starts with ‘dear parents’ and ends with ‘your sister’ are frequent in schizophrenia. Letters to different persons are written on the same sheet of paper. The same person is addressed in different ways, formally or intimately in one letter. ...Despite the presence of normal orientation, the use of incorrect dates and places is not unusual. An institutionalized catatonic always puts her home address on all her letters, even on those written to her mother.

Freud on the dream

In his *Traumdeutung*, Freud described four activities at work in the formation of the dream, that is, at work on the original tangle of dream thoughts, also referred to as the latent content which ends up as the final product, the dream you remember on awakening. *The original tangle of dream thoughts is thought disordered.* For Freud, what you wake up remembering has been massively reworked during sleep by some kind of necessity to transform the undifferentiated dream thoughts into some sort of coherent unity. This re-working of the disordered dream thoughts is carried out under four headings: condensation, displacement, how the dream is represented and secondary elaboration or revision. For our
purposes, I will concentrate on just two of these secondary processes, how the dream is represented and secondary elaboration.

Again under the tendency toward intelligibility and coherence, how the dream is represented, Freud describes as follows:

\[ \text{when the whole mass of the dream-thoughts is brought under the pressure of the dream work, and its elements are turned about, broken into fragments and jammed tighter – almost like pack ice – the question arises of what happens to... logical connections...what representations do dreams provide for ‘if’ ‘because’, ‘just as’ ‘although’ ‘either-or’ and all the other conjunctions without which we cannot understand sentences or speeches?}^{17} \]

And so there are all sorts of devices at work in the final product to convey these connections.

And when it comes to secondary revision, the tendency to impose sense and coherence on the dream is even more pronounced. Freud refers to the purpose of this tendency as follows:

\[ \text{this function behaves in the manner which the poet maliciously ascribes to the philosophers; it fills up the gaps in the dream structure with shreds and patches. As a result of its efforts, the dream loses its sense of absurdity and disconnectedness and approximates to a model of an intelligible experience. But its efforts are not always crowned with success. ... (appearing) to have a meaning, but that meaning is as far removed as possible from their true significance.}^{18} \]

For Freud, ‘In consequence of the belated appearance of the secondary processes, the core of our being, consisting of unconscious wishful impulses, remains inaccessible to the understanding and inhibition of the preconscious’.\(^{19}\) Simply said, this means that with the attempt at cohesion and sense-making, the final version of the dream has made inaccessible or put out of reach, the core of our being or our unconscious wishes.

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17 S. Freud, The Interpretation of Dreams, SE vol 4 (1900), p. 312
18 Ibid.,p. 490
19 Ibid., p. 603
This parallel between the phenomenon of thought disorder and dream thoughts before the dream work has got to work on them, transforming them into the final product of the dream is acknowledged within French psychoanalysis as the psychotic’s unconscious being ouvert au ciel or ‘open to the sky’. Drawing your attention to this parallel is not simply a curiosity or an academic exercise. In analysis it is a given that we are decentered by language or by the unconscious, which is having a continuous effect without our knowing it. For Lacan, the psychotic is parasitised or decentered by language differently to the non-psychotic. The question then becomes, what is the nature of the ‘sense-making’ or unifying agency at work on language that distances us from, let’s say, being the pure object of the voice or of the look, described in psychiatric nosology as delusions of reference, passivity feelings, etc.?

Returning to Bleuler’s catatonic patient whose thoughts on paper segue from supposed daughter to sister, who gives her home address instead of the hospital address, who puts down 1887 instead of 1906 - what of the possibility of what might emerge if someone, without the obvious prejudice that she is suffering from a morbid process, were to have asked her ‘why do you put down 1887 instead of 1906, or what about you being a sister instead of a daughter’? Such questioning is never an effort to rule out or prove pathology but to presume that even thought disordered discourse is an attempt to remember or to make sense of something? Can you advance what the effect might be if someone were to take her speech seriously? To think about such things is unthinkable; I’m paraphrasing Christian Fierens, from the Free University in Brussels who spoke at a conference in St Vincent’s in 2008 and gave us the memorable analytic view of schizophrenia “(which) can only be comprehended as “what is said schizophrenically””. If one were to listen to what the psychotic says from such a perspective, surely to hold such a position has implications for how the transference in psychosis might evolve – not for one instance minimising how complex it can be. As Harry Stack Sullivan, in his inimitable way, says of the transference in psychosis:

The appearance of a strong positive tendency towards the physician is (thus) attended by an extraordinary augmentation of attention for unfavourable signs, and very slight provocation may lead to a reversal of tendency – from positive to negative, love to hate.\(^{21}\)

Nonetheless, echoing Fierens’ quote and despite the transference difficulties, for Harry Stack Sullivan, the thought of the schizophrenic or manic patient is ‘peculiar’, but thought it is, removing schizophrenic thinking ‘forever out of the simple ‘word salad’ class.’\(^{22}\)

And Lacan doesn’t put a tooth in it,

*such a discovery (of the signifier) can be made only at the cost of complete submission, even if it is intentional, to the properly subjective positions of the patient, positions which all too often one distorts in reducing them to a morbid process, thus reinforcing the difficulty of penetrating them with a not unjustified reticence on the part of the subject.*\(^{23}\)

In other words, if your position as a physician is primarily to look to the peculiarities and irregularities in the patient’s speech to gauge whether or not to increase his or her medication, the game is already lost. It leaves the patient high and dry with no confidence whatsoever that you can help them with the questions they pose in their speech, thought disordered though it may be\(^{24}\) as in the case of Bleuler’s patient who, as part of her questioning, is surely asking ‘Who am I, a daughter or a sister?’

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\(^{22}\) Ibid., p. xxi.
\(^{24}\) The further implication of this statement is that the psychoanalyst, rather than the psychiatrist, is better placed to have an ear for the existential questions posed by the psychotic patient and that it is time for psychiatry to have its own question about the limit of the treatment it offers. After all, irrespective of early detection programmes in psychosis management, the non-adherence rate to medication ultimately averages 50%. However the tragedy remains that, in looking only to commonsense techniques such as psycho-educative initiatives, CBT and other strategies to bolster the mainstay of anti-psychotic medication (A.S. David, ‘Treatment adherence in psychosis’ *British Journal of Psychiatry*, 197 (2010) p 431 – 432) there is, as yet, no concerted questioning within psychiatry of a whole climate of opinion that equates the patient with the brain. In holding that opinion, the psychiatric consensus is limited to knowledge within its own epistemic field, thereby maintaining a non-knowledge of the ‘phenomenal’ field of psychoanalysis. However, with
The core of our being and psychosis

My conclusion is by way of a *cri du coeur* for the human process at stake in psychosis. You may be familiar with Elyn R Saks’ book *The Centre Cannot Hold*. In this extraordinary memoir the author states: ‘While medication had kept me alive, it had been psychoanalysis that had helped me find a life worth living’. I would put it to you that to have a life worth living addresses the core of your being and is as essential as being kept alive. We have to begin to think through the consequence of committing patients to medication along with mechanistic social adjustment programmes as automatically excluding of the patient’s desire. For example in her memoir, when Saks describes the moment of onset, for the first time at age seven or eight, of the ‘disorganisation’ of her thinking, what the analyst mentally notes *above all else* is that ‘consciousness gradually (lost) its coherence’ for her in consequence of her sense of having disappointed her father because she asked him to take her swimming: ‘My heart sinks at the tone of his voice: I have disappointed him’. Every woman knows that her relationship with her father - and her mother, is crucial in shaping her sexual identity as a woman. This is no different if the woman happens to be psychotic! At the moment of this traumatic perception, Saks’ conclusion there and then was that nobody was to know what was happening to her

> Of course, my dad didn’t notice what had happened, since it was happening inside me. And as frightened as I was at that moment, I intuitively knew this was something I needed to hide from him, and from everyone else as well. That intuition – that there was a secret I had to keep – as well as the other masking skills that I learned to use to manage my disease, came to be central components of my experience of schizophrenia

suggestions now emerging in the literature that rather than being ‘neuroprotective’ as was presumed to be the case, anti-psychotic medication may in fact contribute to the decline in brain volume as seen on neuro-imaging of psychotic patients, more questioning may be imminent (J. Moncrieff, ‘Questioning the ‘neuroprotective’ hypothesis: does drug treatment prevent brain damage in early psychosis or schizophrenia?’ *British Journal of Psychiatry*, 198 (2011) p 85 - 87).


In a parallel vein, for young men who succumb to paranoia and sexual confusion and who have no one, outside of an analyst who can know about the laws of sexuation - what of their fate? An understanding of the laws of sexuation, developed by Lacan in the seventies, is absolutely crucial in supporting young schizophrenic men, particularly those in the grip of poussée à la femme or ‘the push toward becoming a woman’, a subjective state that leaves them ashamed, isolated, utterly floundering with no alternative but to keep such confusions hidden.

Let’s leave the final word with that great human being Harry Stack Sullivan who appreciated the scale of the complete foreclosure of any serious engagement with the sexual question that afflicts young men who are psychotic. He was convinced that this was an area of their lives that society continued to ‘selectively inattend’. Eighty or so years ago, it was his view that ‘there seems to be little consensual validation among either professional or custodial staff and / or the family as to how the sex interests and behavior of young adolescents … are to be viewed’. Has there really been any change in this attitude over the years? We could all benefit from re-reading how he went about offering an intensive psychoanalytically informed treatment for the young psychotic men in his ward at Sheppard-Pratt in the thirties. At this remove, the sustained effort to drag the young men in his charge out of psychosis by engaging intensively with them on their sexual question, coupled with ‘taking on’ the highly charged psychotic transference makes for remarkable and gripping reading. Thank you for your attention.

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27 H. Stack Sullivan, op.cit., p. xxiii.