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' [1] 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 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

[1] D. Burston, 'Psychoanalysis, Psychiatry and Bipolar Disorder in the Twenty First Century', *The Letter* 46 (2011) p.3.

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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 *Wikepedia* 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 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

[2] Emil Kraepelin – *Wikipedia, the Free Encyclopedia*. 20/7/2011

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* [3]

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.'[4] 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:

> *'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*[5]

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

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[3] J. Lacan , *Ecrits* 'De nos antécédents'. (Paris: Seuil, 1966). p. 65. [My translation]

[4] J. Lacan , *De la psychose paranoïaque dans ses rapport avec la personnalité*, Paris: Librarie le Francois,1932.

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

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.*[6]

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 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

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[6] J. Lacan ,'*De nos antécédents',* op.cit. p. 66.
[7] J. Lacan, *Family Complexes in the Formation of the Individual*, (1938). Unpublished translation by Cormac Gallagher, c.f. www.lacaninireland.com, p. 66.

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 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*

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[8] T. G. Dalzell. *Freud's* Schreber *between Psychiatry and Psychoanalysis: On Subjective Disposition to Psychosis,* London: Karnac, 2011.

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.

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'".[10] 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.

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[9] ibid., p.128

[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.

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.

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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[11] S. Freud, *On Beginning the Treatment*, S.E., X11, p.124.

He wasn't clever at all: he merely told
The unhappy Present to recite the Past
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.[12]

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.[13] 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 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

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[12] W. H Auden. 'In Memory of Sigmund Freud', *Collected Shorter Poems 1930-1944*, Faber. London, *mcml*, p. 171-175

[13] S. Freud. *Recommendations to Physicians Practising Psychoanalysis.* S.E. X11. p.115.

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 secretively 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.

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[14] R. Clarke, *Freud: the man and the cause*, Jonathan Cape, London, 1980, p35.
[15] S. Freud, *The origins of psychoanalysis*, Imago, London, 1954

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 quarters*[16] *as a case of '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 [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.*[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:

> *I am aware that there are psychiatrists who hesitate less often in their differential diagnosis, but I have become convinced that just as often they make mistakes.*[19]

This is not to say that his procedure leads to certain diagnosis: '...it is only one precaution the more'[20]

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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.
[17] My emphasis
[18] S. Freud. *A Case of Infantile Neurosis.* S.E. XVII. p. 8.
[19] S. Freud. *On Beginning the Treatment.* S.E. X11. p.124.
[20] Ibid., p.125

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 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 ...*[21]

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. 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*

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[21] D. Burston, *op. cit.* p. 11

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.[22] He used the hallowed method of the psychiatric case-presentation – 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:

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[22] I have discussed my own experience of Lacan’s case presentations in C. Gallagher, *The patient as actor: notall in the case presentation*, The Letter Issue 42, Autumn 2009. pp 1-13

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. [23]

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.[24].

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

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…[25]

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[23] J. Lacan. *The Knowledge of the Psychoanalyst* (1971-72), trans C. Gallagher. Seminar of 6.Jan 1972. p. 9.
[24] For a blistering attack by an eminent neurologist on the contemporary attempts to reduce human thought and affect to 'brain-talk' see R. Tallis. *Aping Mankind: Neuromania, Darwinitis and the Misrepresentation of Humanity*, Durham. Acumen. 2011.
[25] Christian Fierens. *Lecture de l'étourdit, Lacan 1972.* Paris. Harmattan. 2002. Unpublished translation by C. Gallagher available on www.lacaninireland.com

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

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[26] I. Brown. *The Irish Times Healthplus,* 'The Great Illusion', Dublin. 12 October 2010, p.17.

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]

Address for correspondence:

Cormac Gallagher
Fair Field
130 Mount Anville Park
Dublin 14

cormacgallagher@eircom.net

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[27] D. Burston, op.cit. p. 11